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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KVI1

Facility ID: 00634

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/01/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10. THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

Reduction in the number of certified SNF/NF beds from 73 beds to 70 beds, effective January 1, 2019, in accordance with a change in licensure. Due to three beds being placed in layaway status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective January 1, 2019, all 70 facility beds are certified SNF/NF. After this change they have six (6) beds on layaway.

17. SURVEYOR SIGNATURE — Kathleen Lucas, Unit Supervisor — Date: 11/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Alison Helm, Enforcement Specialist — Date: 11/06/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/18/2018** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 6, 2018

CMS Certification Number (CCN): 245339

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

Dear Administrator:

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

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

Effective October 29, 2018 the above facility is certified for:

73 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 6, 2018

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

RE: Project Number S5339027

Dear Administrator:

On October 3, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on September 20, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 1, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 5, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 20, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 29, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 20, 2018, effective October 29, 2018 and therefore remedies outlined in our letter to you dated October 3, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

An equal opportunity employer.

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KVI1

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(L4) **230 CHURCH AVENUE, BOX 676**
(L5) **ALBANY, MN** (L6) **56307**

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7. On-Site Visit 9. Other
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FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

14. LTC CERTIFIED BED BREAKDOWN

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	73			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Christine Bodick-Nord, HFE NE II 10/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 10/17/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
October 3, 2018

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

RE: Project Number S5339027

Dear Administrator:

On September 20, 2018, a standard survey was completed at your facility by the Minnesota Department of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is October 30, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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.

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.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 20, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 20, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 ______ B. WING ______	09/20/2018

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 A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on September 17, 18, 19 and 20, 2018 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		10/29/18

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

Electronically Signed — 10/10/2018

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 ______	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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E 041	Continued From page 2 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation and document review the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all 68 residents and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: During the facility tour and interview with on 9/18/18, between 9:00 a.m. to 1:00 p.m. the following observations were made	E 041	a & b) The weekly checks and load bank test of generator could affect the safety of all residents if the generator failed to operate during a power outage. c) Contractor will perform generator load bank test on 10/29/18. Weekly tests of generator have been logged since 12/13/17 and will be maintained ongoing. d) Ron Zierden, Director of Environmental Services or designee will be responsible for correction and monitoring of generator testing to prevent reoccurrence of deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 3 1) The weekly generator log was not completed for 12/6/2017-12/13/2017 due to the generator not being functional. 2) Annual load bank test was not performed. This deficient conditions was confirmed by the Environmental Services Director.	E 041	e) Completion date of deficiency is 10/29/2018.	
F 000	INITIAL COMMENTS On September 17, 18, 19, 20, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		10/28/18

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	245339	A. BUILDING ______ B. WING ______	09/20/2018

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

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F 609	Continued From page 4 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an allegations of misappropriation of missing money was reported to the State Agency (SA) and the administrator for 1 of 1 resident (R26) reviewed for allegations of missing money. Findings include: R26's resident face sheet undated indicated R26's diagnoses included diabetes mellitus. R26's annual Minimum Data Set (MDS) indicated R26 was cognitively intact and required the assistance of one staff with activities of daily living	F 609	a) R26 stated the alleged missing money occurred on 10/3/17 when out of her room for church. Investigation and review of camera showed that no staff entered R26's room while she was out of the room on 10/3/17. R26 did not leave her room on 10/3/17 other than to attend church, R26 declined to file a police report. b)All residents are subject to a possible report not being submitted, but no other instances of alleged violation not being submitted discovered for time period reviewed 8/17,9/17,10/17. No other	

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F 609	Continued From page 5 (ADL). During an interview on 9/17/18, at 6:20 p.m. R26 stated $40.00 was missing from R26's room. R26 stated the five dollars was for the collection plate at church and the rest was in my wallet. R26 stated the nurses were told and I did not get my money returned. R26 did not want to file a police report. An interview on 9/18/18, at 1:58 p.m. the director of social service (DSS) stated if there were problems staff will fill out a grievance form, missing items form and give it to me. DSS stated R26's family did notify them of the missing money. DSS stated the SA was not notified because DSS could not verify R26 had any money in R26's room. DSS stated we did not know if the money existed. An interview on 9/20/18, at 10:15 a.m. with the director of nursing (DON) stated abuse training is conducted annually on the computer for the staff and when hired. The DON state theft is abuse and should be reported to the SA immediately or in two hour window. The DON stated if a resident were missing $40.00 it should be reported to the SA. An interview on 9/20/18, at 10:26 a.m. with the assistant director of nursing (ADON) stated we do not need to report to the SA if a resident is missing money. The ADON stated residents are offered a lock box for valuables or they can put them in the business office, the residents are made aware that they are at their own risk if they do not lock up their valuables. An interview on 9/20/18, at 11:11 a.m. the	F 609	instances of missing money reported during time period reviewed. c) Facility policy and procedure for reporting will be reviewed with DON,RN managers, and social workers, along with any reportable events being reported to DON and Administrator immediately. Either DON or RN managers are on call at all times. Vulnerable Adult Protection education for all departments will be completed by 10/28/18. d) Reports and timeliness of all reports will be reviewed at QAA/QAPI committee meeting. e) Correction date 10/28/18. Administrator and/or DON will be responsible for ongoing compliance	

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F 609	Continued From page 6	F 609		

administrator stated they report to the SA maltreatment, abuse, significant injuries, bruising of unknown origin, resident to resident altercations and criminal things like missing money. The administrator stated staff are required to report these things to me also. The administrator stated a log was kept of the incidents reported to the administrator and no missing money allegations had been reported in August, September, or October 2017. The administrator stated he should have been made aware of this immediately and should have told law enforcement too.

A Grievance and Missing Items Form dated 10/3/17, indicated R26 went to church and R26's family closed the door to the room. R26 noticed on 10/3/17 that $40.00 was missing from the wallet that was kept in the dresser by the door. Also the form indicated the administrator needed to be notified immediately of possible vulnerable adult/abuse/maltreatment. There was no date or time the administrator was notified.

A review of the facilities OHFC (office of health facility complaints) log did not indicate any missing money allegations were reported to the SA from the facility.

The facility policy Abuse Prevention and Vulnerable Adult Procedure undated, indicated all residents residing in the facility will be protected from maltreatment. The facility requires all suspected maltreatment be reported promptly. The Professional or Professional's delegate, while engaged in the care of vulnerable adults will make sure that a report is made out, that the internal investigation begins immediately, the appropriate reporting takes place and

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F 609	Continued From page 7 interventions are implemented to provide the vulnerable adult with a safe living environment. When in doubt be sure to report. The administrator is notified immediately.	F 609		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions to prevent and treat pressure ulcers were implemented for 1 of 3 residents (R57) reviewed for pressure ulcers. The findings include: R57's admission Minimum Data Set (MDS), dated 8/23/18 identified 57's was severely cognitively impaired. R57 required extensive assist for bed mobility, transfers, dressing, and toileting. R57 was at risk for pressure ulcers. Interventions included a pressure reducing device in bed and chair.	F 686	a) R57's plan of care was changed after a pressure ulcer developed. The changes were not made timely to both care plan and RIS sheet. Pressure ulcer has resolved as of 10/5/18. b) All residents who are at risk for development of pressure ulcers would be at risk due to deficient practice. c) RN managers have been re-educated on the need for complete and timely changes to care plans and RIS sheets. d) All care plans will be reviewed by RN	10/28/18

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F 686	Continued From page 8 R57's care plan, dated 9/4/18, indicated R57 was at risk for pressure ulcers, skin was intact. Interventions to maintain intact skin integrity included to turn/reposition/offload R57 approximately every 2 hours. Additional interventions included a pressure reducing mattress. The care plan lacked direction for the use of a pressure reducing wheelchair cushion. R57's progress note dated 9/8/18, indicated R57 had developed a 0.9 cm x 0.3 cm open area to the coccyx. Tegaderm foam dressing applied to prevent friction and sheer. Staff directed to turn R57 from side to side. Although a pressure reducing wheelchair cushion was identified as a previous intervention, the note indicated "Wheelchair cushion added to wheelchair with Dycem (non-slip mat)". R57's progress note dated 9/10/18, identified registered nurse (RN)-C assessed R57's coccyx wound. RN-C assessed the wound as a stage II pressure ulcer (blistering, cracking, or abrasion to the skin). The pressure ulcer measured 0.4 cm x 0.5 cm and had 100% epithelial tissue present to wound bed. Interventions included Tegaderm dressing every 3 days and as needed to protect area for pressure and shearing, off loading "at least" every 2 hours, laying down in the afternoon with side to side repositioning in bed, and cushion in wheelchair. R57's physician orders identified a 9/10/18 nursing order to monitor R57's coccyx every shift and change the Tegaderm foam dressing every 3-7 days. A 9/15/18 nursing order to turn R57 from side to side when in bed to keep pressure off coccyx.	F 686	managers at least quarterly and with any change of condition. Development of any pressure ulcers are discussed at QAA/QAPI and examined for root cause. e) Correction date 10/28/18. DON will monitor compliance.	

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F 686	Continued From page 9	F 686		

Review of R57's care plan on 9/18/18 lacked revision to include the development of the pressure ulcer and updated interventions, including the change of offloading from approximately every 2 hours to at least every 2 hours as assessed on 9/10/18.

During continuous observations on 9/18/18, at 10:57 a.m. R57 was in the dining room attending a group activity. R57 was sitting in a wheelchair. R57 was sitting on a black cushion. At 11:58 p.m. group ended. Staff did not offload or offer repositioning or toileting. R57 at a dining room table awaiting meal. At 12:36 p.m. R57 received meal and staff assisted with meal. At 1:33 p.m. nursing assistant (NA)-A stated to R57 "lets go to the bathroom." NA-A assisted R57 to the toilet using the stand lift. After NA-A removed R57's incontinent brief, NA-A stated R57 was incontinent of stool and urine. Observations to R57's coccyx revealed a foam dressing dated 9/15/18. R57's coccyx and buttocks had no redness or discoloration. After completing toileting and providing incontinence care, NA-A assisted R57 to bed using the stand lift. No offloading or repositioning was provided or offered during the 2 1/2 hours of constant observations.

During an interview on 9/18/18, at 1:52 p.m. when asked about turning/repositioning/offloading, NA-A stated it's "suppose to be every 2 hours." When asked the last time R57 was repositioned, NA-A stated one of the other nursing assistants toileted R57 prior to lunch, but did not know which one. NA-A went on to say 3 nursing assistants were working. NA-A identified the other 2 nursing assistants as nursing assistant NA-B and nursing

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F 686	Continued From page 10	F 686		

assistant NA-C. NA-A stated residents are not assigned to a specific nursing assistant and duties are shared between all 3 nursing assistants. When asked how she knows when a resident was repositioned, NA-A stated repositioning times are documented on the repositioning board. NA-A reviewed the repositioning board, located at the nursing station. The repositioning board lacked documentation of repositioning for 9/18/18. NA-A stated the last time repositioning was documented was the previous evening, 9/17/18. NA-A stated the last time she provided cares, including repositioning for R57 was approximately 7:30 a.m., when she assisted R57 with morning cares and getting R57 up in her wheelchair.

During an interview on 9/18/18, at 2:07 p.m. NA-C stated nursing assistants are not assigned to specific residents. NA-C stated R57 is repositioned every 2 hours. When asked how she knows when R57 was repositioned, NA-C stated she communicates with the other nursing assistants throughout the day. NA-C stated she had not assisted R57 with cares on 9/18/18, including repositioning.

During an interview on 9/18/18, at 2:12 p.m. NA-B stated staff are not assigned residents. When asked how she knows when a resident was repositioned or toileted, NA-B stated "we usually ask the other aides." NA-B stated the nursing assistants are trying to get in the habit of documenting repositioning on the clip board, but that does not always happen. When asked about the repositioning board for 9/18/18, NA-B looked at the board and stated "one was not set up today." NA-B stated she had not assisted R57 with cares on 9/18/18, including repositioning.

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F 686	Continued From page 11	F 686		

During an interview on 9/19/18, at 1:10 p.m. registered nurse (RN)-C stated upon admission, R57 was assessed to be at risk for pressure ulcers. RN-C stated all mattresses are pressure reducing. RN-C stated R57 developed a stage II coccyx pressure ulcer on 9/8/18. RN-C stated the intervention of a pressure reducing chair cushion was not initiated until after the pressure ulcer developed on 9/8/18, when the nurse who identified the pressure ulcer initiated a wheelchair cushion. RN-C stated a new intervention of turning from side to side in bed was also initiated on 9/8/18. RN-C stated she updated R57's care plan to include the development of the pressure ulcer and new interventions; however, after reviewing R57's care plan RN-C stated the care plan was not updated. RN-C stated nursing assistants are not assigned to residents during the day. RN-C stated staff are to refer to the turning and repositioning sheet to determine when a resident needs to be offloaded/ repositioned. RN-C stated the day shift was not very good about documenting on the form, but have been getting better at it.

During an interview on 9/20/18, at 1:55 p.m., the director of nursing (DON) stated staff are to implement interventions as assessed.

The facility's policy Prevention of Pressure Ulcers, revised January 2002 directed a resident's risk factor is assessed on admission, quarterly and with a significant change in status using the risk scale identified by protocol. Risk factor preventive actions include for a person in a chair to change position at least every 2 hours and use a foam, get or air cushion as indicated to relieve pressure. Persons confined to chairs

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F 686	Continued From page 12 should be repositioned at least every 2 hours. Persons confined to chairs who are unable to shift their own weight may need repositioning more frequently. The facility's policy Care Planning, revised 8/8/17, directed the RN unit manager will ensure that each plan of care includes information related to the resident's treatment, wellness, and recovery. The RN unit manager will ensure periodic review of the care plan based on resident's individual needs, which include when warranted by changes in resident's medical condition. When changes in goals, objectives, or interventions are identified.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 688	a) R5's restorative program for PROM to	10/28/18

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F 688	Continued From page 13 facility failed to provide restorative nursing services to maintain mobility and range of motion for 2 of 2 residents (R57, R5) reviewed for range of motion. This had the potential to affect all 38 residents receiving restorative nursing services. Findings include: R57's admission Minimum Data Set (MDS) dated 8/23/18, indicated severe cognitive impairment. R57 received extensive assistance for bed mobility, transfers, dressing and personal hygiene. R57 had impairment bilaterally of lower extremities. Physical therapy started on 8/20/18, and was not currently on a restorative nursing program. R57's Physical therapy Daily Treatment note, dated 9/5/18, indicated passive range of motion (PROM-staff assisting with moving joints) was completed to bilateral ankle, knee and hip. R57 put on a restorative nursing program (RNP) for PROM. Nurse manager and restorative staff updated/educated. "form turned into appropriate staff." R57's Therapy Department form for Restorative Nursing Program, dated 9/5/18, directed lower body PROM seated. See handout provided. Encourage active ROM with exercises 4-5 times weekly. Handout included directions for PROM 15-20 repetitions each leg. R57's care plan, dated 9/5/18, indicated R57's care plan was updated to include an individualized restorative nursing program to maintain ROM and joint integrity 4-5 times weekly as directed on therapy form. Rehabilitation nursing to complete.	F 688	his upper and lower extremities has been assigned for overnight staff to complete. R57's was reviewed with therapy team who suggested that the frequency per week be decreased to 2-4 times weekly, with a minimum of 8 episodes per month instead of 4-5 times weekly due to fatigue. b) DON and ADON and unit management team met with therapy team lead on 9/25/18 to review all restorative programs for residents involved that may be impacted by this deficiency. Two programs were discontinued due to non-participation. The remaining programs for each resident were reviewed and revised as necessary.Therapy will discuss with therapy aide any additions to ensure appropriate program is managed. c) The restorative aide will work in this capacity routinely from 9 am to 2:30 pm without interruptions. All will be done by scheduler or staff to replace or make other lateral moves. d) The restorative nurse will complete random checks of 5 different resident's logs each week X 2 months to ensure minimum frequency is obtained, and thereafter continue monthly.There will be a monthly meeting with RA, therapy lead and DON/ADON to assess that residents are maintaining and adjust as needed, and also discuss any lack of participation or change in condition. Audits will be reviewed at this monthly meeting. e) Correction date 10/28/18.	

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F 688	Continued From page 14 Review of restorative aide documentation, located in the restorative aide book, revealed a September 2018 calendar. Documentation between 9/5/18 and 9/19/18 revealed documentation of ROM on 9/6/18. All other dates were blank. During an interview on 9/19/18, at 11:06 A.M., the assistant director of nursing-registered nurse (RN)-B stated the facility currently have 2 restorative aides, nursing assistant (NA)-D and nursing assistant NA-E. The restorative aides follow the recommendations for the nursing restorative program made by therapy and document the completion in the restorative books. RN-B stated when a floor aide cannot be replaced, sometimes the restorative aides get pulled to work on the floor. When asked how often this occurs, RN-B stated "I would have to ask them (NA-D and NA-E)". RN-B reviewed the September 2018 nurse restorative documentation for R57 and stated it looked like "its not being done." RN-B stated the restorative aides do the best they can with getting the ROM completed. RN-B stated the ROM is a recommendation from therapy and not physician ordered. During an interview on 9/19/18, at 10:31 a.m., NA-D stated R57 was put on a RNP not too long ago. NA-D stated R57 is currently scheduled 4-5 times weekly for PROM. NA-D stated he completed ROM one time for R57, on 9/6/18. During a follow up interview on 9/19/18, at 11:18 a.m., NA-D stated there was currently 38 residents on the restorative nursing program. NA-D stated he works for 4 hours on the floor, then has the remaining 4 hours to complete the	F 688	ADON will be responsible for correction and monitoring.	

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(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 688	Continued From page 15	F 688		

restorative aide schedule. NA-D stated when there are staff call in's he gets pulled to work the floor. NA-D stated between the high case load and being pulled to the floor to work, he is unable to complete resident therapies as scheduled.

During an interview on 9/19/18, at 11:33 a.m., NA-E stated when someone calls in, she works on the floor. NA-E stated she tries to make up the days on the weekend. NA-E stated over the past few weeks she was pulled from the RNP and worked on the floor several times. NA-E stated there was a lot of residents of the restorative list and cannot complete the restorative therapy for all the residents. When asked about ROM for R57, NA-E stated "I have not seen her yet myself, no."

During an interview on 9/19/18, at 12:18 p.m. physical therapy assistant (PTA)-C stated R57 was discharged to a restorative nursing program on 9/6/18. The recommendations were for PROM 4-5 times weekly. PTA-C stated the frequency of ROM is important to keep R57's joints moving. PTA-C completed a screening to evaluate for any changes in ROM since 9/6/18. PTA-C stated R57's ROM remained unchanged.

R5's quarterly minimum data sets (MDS) dated 6/6/18, indicates R5 has a diagnosis of persistent vegetative state and is totally dependent on staff for all activities of daily living, and requires staff to anticipate all needs.

R5's care plan with a revision date of 9/19/18, indicated R5 was on a restorative nursing program to prevent increase in joint contractures and to maintain comfort. R5's passive range of

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F 688	Continued From page 16 motion (PROM) included left hip flexion, right and left knee flexion, bilateral hip abduction, bilateral ankle flexion, bilateral shoulder flexion, bilateral elbow flexion and bilateral wrist flexion three to four times a week. R5's Care Area Assessment (CAA) dated 6/4/18, indicated R5's May restorative nursing charting was poor. R5's daily PROM was done only 7 times for the month of May 2018. The CAA indicated no change to R5's range of motion and no decline, no referrals needed, and to continue with the current plan of care. R5's Restorative Nursing Program dated 7/25/18, by the therapy department, indicated R5's goal with PROM program was to maintain joint mobility, comfort and to prevent further contractures. R5 had daily PROM to bilateral upper extremities shoulder, elbow, wrist and daily PROM to lower extremities hip, knee and ankle. The bottom of the restorative nursing program sheet had R5's daily PROM crossed off and a date of 6/11/18, changing the frequency of PROM from daily to three to four times a week. R5's nursing assistant care sheets undated, did not direct staff to complete R5's PROM. R5's restorative treatment monthly logs indicated the days R5 received restorative nursing for the following months: April 2018- 1 time May- 7 times June-10 times July- 8 times August- 12 times September 1st - 20th- 5 times.	F 688		

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F 688	Continued From page 17 During interview on 9/20/18, at 11:19 a.m. nursing assistant and restorative nurse NA-D stated R5's restorative nursing was cut down in frequency because R5's was not getting seen five times a week. NA-D stated R5's days to be seen was decreased to three to four times a week due to not enough restorative nursing hours available. NA-D stated he was getting pulled from his restorative nursing position to help on the nursing floor. NA-D stated getting pulled is nothing new it happens all the time. NA-D stated he know R5 is not getting seen three to four times a week. NA-D further stated there are too many residents on their case load and they don't have enough staff to get the work done. During interview on 9/20/18, at 12:20 p.m. RN-B stated restorative nursing is a recommendation from therapy, it is not an order. RN-B stated if facility is unable to replace sick calls for nursing on the floor, they do pull the restorative aide to help out until cares are completed. RN-B stated she know restorative nursing has been "lagging". RN-B stated R5 has not declined with his range of motion, he has been here for a long time and his contractures do not look any worse. RN-B stated she is not saying restorative nursing should not be done, just that R5 has not had a decline in his range of motion. RN-B further stated she has talked to the therapy staff and knows the restorative program is getting bigger and bigger and they don't have the staff to have the restorative program. RN-B stated that all we have ever had is one restorative staff, and one is not enough. During interview on 9/20/18, at 12:58 p.m. director of nursing (DON) stated The facility has to adjust cares when they have sick calls they are	F 688		

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F 688	Continued From page 18 unable to be replaced. The DON stated the restorative aide gets pulled from their duties first as there is no place else to pull from. DON stated patient cares come first and restorative is an add on and she does not have anywhere else to pull from. The DON stated she is shorter on staffing then she would like to be and it is tough to replace staff when they call in sick. During interview on 9/20/18, at 1:44 p.m. Physical therapy assistant (PTA)-A stated it would be good for nursing to follow the recommendations made by therapy so the residents are less likely to decline. A policy titled, Restorative Nursing and Rehabilitative Program identified it was a program in place to assist residents in attaining or maintaining their highest level of function, maintain dignity and self-worth, and prevent complications of chronic conditions and that the service is provided seven days a week. The facility's policy Restorative Nursing and Rehabilitative Program, dated 8/16/11, indicated nursing or therapy will identify residents in need of restorative nursing/rehabilitative program. The therapist will develop a program if appropriate and communicate the program to the restorative aides and the RN case manager. Each plan will have individualized goals and the identified tasks to be completed. A schedule will be developed with the oversight of the therapy department. The restorative aide will document on the flow sheet the number of minutes for each task completed.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/28/18

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F 689	Continued From page 19 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions to minimize the risk of falls were implemented for 2 of 2 residents (R57, R65) reviewed for falls. Findings include: R57's admission Minimum Data Set (MDS), dated 8/23/18, R57 required extensive assistance of 2+ staff for transfers and toileting. R57 had a fall within the month preceding admission. R57 was severely cognitively impaired. R57's Fall Risk Assessment, dated 8/23/18, indicated R57 was at high risk for falls with extensive assistance of 2 staff for transfers. R57's care plan, dated 9/4/18, indicated R57 was a high risk for falls. R57 receives extensive assist of 2 with transfers. "Refer to therapy prn (as needed), follow therapy recommendations as they occur." Do not leave in bathroom unattended during toileting. A physical therapy Daily Treatment Note, dated 9/6/18, indicated R57 transfers from surface to surface with an EZ stand (mechanical device). Therapy recommended 2 staff assist with the EZ stand due to fall risk and R57's resistance to	F 689	a) There were no negative outcomes to R65 and R57. No falls occurred. b) All residents requiring assistance with transfers would be considered at risk if care plan for safe transfers not followed. c) All care plans and RIS sheets are being reviewed for accuracy and completeness. Nursing staff are all required to do return demonstrations to Director of staff development, or RN manager on or before 10/28/18. Nursing staff will complete online fall prevention training by 10/28/18. The return demonstrations and fall prevention training will continue to be mandatory annually. d) The monthly falls meeting to review root cause as well as assess current interventions, led by DON, with nurse management, social service and activities, in addition to a review at QAA/QAPI e) Correction date 10/28/18. DON will be responsible for ensuring above is completed and ongoing.	

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F 689	Continued From page 20 lower extremity maintenance program. "Due to the variability of staff that is scheduled on the floor each day, and until patient is consistently transferring with less assistance and improved posture, patient will remain 2 assist." The resident information sheet (RIS-used by nursing assistants when providing cares), undated, but, provided on 9/18/18 directed 2 assist with EZ-stand to toilet. 2 assist with EZ-stand with transfers. During observations on 9/18/18, at 1:28 p.m. nursing assistant (NA)-A pushed R57 in her wheelchair from the dining room to her room. NA-A left the room and returned with an EZ-stand lift. NA-A placed R57's feet on the EZ stand platform and secured the leg strap around R57's legs. NA-A placed a harness around R57, and attached the loops of the harness to the lift. NA-A did not call for assistance. NA-A lifted R57 from her chair using the lift without a second staff present. NA-A pushed the EZ-stand lift into the bathroom. Once in the bathroom, NA-A pulled down R57's pants, removed an incontinent brief, and lowered the R57 to the toilet. At 1:41 p.m., NA-A lifted R57 from the toilet, alone, using the EZ-stand lift. While the resident stood in the lift, NA-A provided perineal care. NA-A was observed to don gloves prior to perineal care and doffed gloves after perineal care. NA-A did not wash her hands after perineal care and prior to donning new gloves. Once finished, NA-A still alone, pushed the EZ-lift from the bathroom to R57's bed and used the controls to lower R57 onto the bed. NA-A lowered R57's bed and provided R57 with a call light before leaving the room. During the transfer, R57 was observed to hold onto the handles of the lift. R57's feet remained flat on the	F 689		

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F 689	Continued From page 21	F 689		

platform.

During an interview on 9/18/18, at 1:52 p.m. NA-A stated the resident information sheet (RIS) she carries directs resident cares. When asked about not washing hands after doffing gloves and prior to donning clean gloves, NA-A stated she should have washed her hands, but was by herself and "I was afraid the way she was standing on the EZ-stand." When asked to review the RIS, NA-A pulled a piece of paper from her pocket. When asked what the RIS directs related to transfers, NA-A stated R57 is to transfer with and EZ-stand and 2 staff. NA-A stated she did not follow the care plan, adding "I usually don't work down this hallway."

During an interview on 9/19/18, at 1:10 p.m. registered nurse (RN)-C stated staff are to transfer R57 with 2 staff and an EZ-stand. RN-C stated sometimes R57 does not hold onto the EZ-stand and family prefers 2 staff and EZ-stand do to R57's unpredictable behavior. RN-C stated the EZ-stand and 2 staff was also recommended by therapy.

During an interview on 9/20/18, at 1:56 p.m. the director of nursing (DON) stated staff are to follow the RIS. The DON stated she was informed NA-A did not follow R57's care plan, and provided a reminder to NA-A to follow all directions on the RIS.

A facility policy Falls Prevention, revised 1/18/18, directed for residents found to be at high risk and /or have a history of falls, interventions to prevent falls will be put into place. These interventions will be put on the resident's care plan.

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F 689	Continued From page 22	F 689		

A facility policy Mechanical Lift/Safe Patient Handling Policy, dated 7/28/17, indicated "All lifting and transferring of patients/residents will be performed according to their individual plan of care."

R65's significant change minimum data sets (MDS) dated 8/31/18, indicated R65 required extensive to total assist of 2 staff for transfers and toileting and had severely impaired cognition. R65 had diagnoses of dementia, Parkinson disease, pneumonia, hemiplegia, and congested heart failure. R65 was recently admitted to hospice care on 8/25/18 related to progressive weakness, decline and medical diagnoses.

R65's Care Area Assessment dated 9/9/18, indicates R65 is at high risk for falls related to impaired mobility, medical diagnoses, and medication use. R65 required extensive assist with all activities of daily living and uses the EZ stand for his transfers.

R65's care plan dated 9/17/18, at 10:50 a.m. indicated R65 required assist with transfers related to mobility status and intermittent confusion and R65 will continue to bear weight for transfers with the EZ stand. R65 is to use the EZ lift when weaker.

During observation on 9/17/18, at 1:01 p.m. R28 was transferred from wheel chair to the toilet per the EZ stand with two staff assist. R65's feet were not flat on the EZ stand foot rest, only his tip toes touched the flat surface. R65 could not support his lower extremities, his arms were both way up in the air over his shoulders and he was hanging from the EZ stand during his transfer.

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F 689	Continued From page 23 During observation of R65's transfer on 9/17/18, at 7:04 p.m. nursing assistant (NA)-I said to NA-J that R65 looked tired and was not sure if R65 could use the EZ stand, further stating "he might be to tired or weak". NA-J shrugged her shoulders and the two aides continued to use the EZ stand for R65's transfer. R65's arms were up in the air over his shoulders, he was hanging and was unable to assist with the transfer in anyway. R65's tip toes were on the EZ stand platform and not supporting him. NA-I stated R65 had a decline in the past few weeks. During interview on 9/18/18, at 11:57 a.m. RN-D hospice nurse stated she had noticed a weakness in R65's legs and would look to see if R65 was a EZ stand or EZ lift for transfers. RN-D hospice nurse stated she is not R65's regular hospice nurse and would need to check some information from other nurses. During interview on 9/18/18, at 1:17 p.m. NA-K and NA-L were going to transfer R65 and were bringing the EZ lift into R65's room. NA-L stated she was just told by RN-B to change R65 to a EZ lift only from now on and not to use the EZ stand for transfers. During interview on 9/18/18, at 2:05 p.m. RN-B stated the hospice nurse called the administrator or director of nursing (DON) and told them to change his care plan to the EZ lift instead of the EZ stand. RN-B stated " it just so happened R65 declined enough today that hospice nurse noticed it and called to tell the facility". RN-B stated R65's condition changed so fast. R65's Progress note dated 9/18/18, at 2:14 p.m. indicated R65 was switched to a hoyer lift for all	F 689		

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F 689	Continued From page 24 transfers per hospice recommendation. RN-B indicated R65 had a decline in the last day warranting the change. During interview on 9/18/18, at 2:23 p.m. The DON stated hospice nurse sent an email regarding the change from EZ stand to the EZ lift. The DON stated the hospice nurse was uncomfortable telling DON the transfer was unsafe when she was in the facility. The DON stated "as far as I know R65's transfer was safe today before the changes of R65's transfer status changed. R65's care plan revised date of 9/20/18, indicated R65 required assist with safe transfers related to mobility status and intermittent confusion and needs the EZ lift for transfers/hoyer lift with 2 staff assist. A facility policy Falls Prevention, revised 1/18/18, directed for residents found to be at high risk and /or have a history of falls, interventions to prevent falls will be put into place. These interventions will be put on the resident's care plan. A facility policy Mechanical Lift/Safe Patient Handling Policy, dated 7/28/17, indicated "All lifting and transferring of patients/residents will be performed according to their individual plan of care."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		10/28/18

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F 695	Continued From page 25 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure continuous oxygen therapy was administered according to the care plan for 1 of 1 residents (R28) observed receiving oxygen therapy. In addition R28's current physician orders were lacking orders for oxygen. Findings include: R28's significant change Minimum Data Sets (MDS) dated 8/3/18, indicated R28 is cognitively impaired, required extensive assist with all activities of daily living, and had diagnoses including chronic obstructive pulmonary disease (COPD), pulmonary emphysema, pneumonia and Parkinson's disease. R28 has shortness of breath, trouble breathing with exertion and when at rest and is on continuous oxygen therapy. R 28's care plan date last reviewed 7/31/18, indicated respiratory impairment related to his COPD and pulmonary emphysema and required continuous oxygen to maintain therapeutic oxygen saturations above 90 percent. The care plan also indicated R28 was on continuous oxygen per nasal cannula at 2/liters per minute. R28's Care Area Assessment indicates R28 is oxygen dependent at 2 liters per minute. R28's treatment administration record dated	F 695	a) Resident R28 had no significant decline in respiratory function related to the O2 tank having gone empty.R28 has physician orders for O2 at 2L per nasal cannula. b) All residents requiring O2 or other treatments could be adversely affected by the deficient practice. c) All nurses and TMA's have been re-instructed on the procedure for treatments regarding not signing as completed until it has been completed. Treatment order is to check portable O2 tank every 4 hours and fill prn to maintain supply. The oxygen tank checks are on the physician orders for nurse or TMA to initial after completing. Note that R28 was previously on every 2 hour checks due to not having concentrator in room, but checks now changed to every 4 hours. d) Nurse managers on each unit will complete weekly spot check sign out's for treatments to ensure that none are signed out prior to completion for 2 months. QAA/QAPI will review progress on this tag. e) Correction date 10/28/18.	

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F 695	Continued From page 26 month of September 2018, indicated R28 required staff to check portable oxygen tank every two hours and as needed to maintain continuous supply of oxygen at 2 liters per minute by nasal cannula. R28's physican order dated 8/20/18 through 9/20/18, was lacking orders for oxygen. During observation on 9/17/18, at 1:43 p.m. R28 was up with oxygen on at 2 liter per minute walking in hallway with his walker and two staff assist with ambulating. R28 was short of breath when he returned to his room and his oxygen saturations were 87 percent due to his exertion with walking. R28 rested for two minutes and his oxygen saturations came back up above 90. During observation on 9/17/18, at 4:47 p.m. R28's portable oxygen tank displayed being in the red zone on the regulator, indicating oxygen tank was empty, and R28 was not receiving any oxygen through his nasal cannula. During interview on 9/17/18, at 4:47 p.m. registered nurse (RN)-D stated R28's tank was empty and said he was not receiving any oxygen through his nasal cannula. R28's respiratory rate was 24 breaths per minute and his breathing was labored when R28 said he could "use a fill again". RN-D left to get a new full portable tank of oxygen for R28. During interview on 9/20/18, at 10:27 a.m. nursing assistant (NA)-F stated R28 does not have an oxygen concentrator in his room, only has the portable oxygen. NA-F stated she checks the residents oxygen tanks for level of oxygen left in the tank when she arrives at work, when giving	F 695	DON will be responsible for ongoing compliance.	

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F 695 Continued From page 27 F 695

cares and every two hours there after during her working shift. NA-F stated she is not sure the last time R28's oxygen level in tank was checked however, stated she was sure another nurse checked it since she last checked at 8:00 a.m. NA-F was unable to say at what times the tank was checked. NA-F stated that R28 yells down the hallway that he needs oxygen if his oxygen runs out.

During interview on 9/20/18, at 10:36 NA-G stated she always checks the portable oxygen levels in the tanks when dealing with the residents when they are at breakfast or lunch. NA-G stated she is not sure how often the oxygen levels in the tank are checked but she will find out. NA-G stated it is every two hours when portable oxygen tanks are checked. NA-G stated she keeps track of when tanks need to be checked in her head, that she does not write it down and she will ask other NA's when they checked the portable oxygen tanks.

During interview on 9/20/18, at 10:43 a.m. NA-H stated she checks the portable oxygen tanks when she gets the residents up in the morning and before every meal. NA-G stated we monitor as much as we can so the tanks do not go empty. NA-G stated she is not sure what time R28's tank was last checked for oxygen level.

During interview on 9/20/18, at 10:48 a.m. RN-A stated the portable oxygen tanks are checked every two hours and are document in the computer when the tank was checked. RN-A stated usually the person checking the oxygen levels in the tank is the one who gets them up in the morning or brings them back to their room. RN-A stated R28 will tell the nurses when he is out of oxygen.

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F 695	Continued From page 28 During interview on 9/20/18, at 10:54 a.m. RN-C stated R28's oxygen level in tank gets checked every 2 hours. RN-C stated there is a treatment record in the medication administration record and the nurses and nursing aides are to document the times the tanks are checked. RN-C stated the nurses may get busy and don't check the tanks or don't document the tanks were checked at times. A facility policy entitled Oxygen Use undated indicates oxygen will be administered according to provider orders.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725		10/28/18

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F 725	Continued From page 29 limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staffing was available in order to implement the restorative nursing program for 2 of 2 residents (R57, R5) reviewed for range of motion. This had the potential to affect all 38 residents receiving restorative nursing services. Findings include: R57's admission Minimum Data Set (MDS) dated 8/23/18, indicated severe cognitive impairment. R57 received extensive assistance for bed mobility, transfers, dressing and personal hygiene. R57 had impairment bilaterally of lower extremities. Physical therapy started on 8/20/18, and was not currently on a restorative nursing program. R57's Physical therapy Daily Treatment note, dated 9/5/18, indicated passive range of motion (PROM-staff assisting with moving joints) was completed to bilateral ankle, knee and hip. R57's put on a restorative nursing program (RNP) for PROM. Nurse manager and restorative staff updated/educated. "form turned into appropriate staff." R57's care plan, dated 9/5/18, indicated R57's care plan was updated to include an individualized restorative nursing program to	F 725	a) R57 and R5 have had no declines related to deficient practice. R5 has been changed to have the PROM done by the night shift staff. R57 is continuing the restorative program per new therapy recommendations. b) All residents on a restorative program would be considered at risk due to deficient practice. c) All programs have been reviewed and revised by therapy manager and nursing. In order to complete programs as assigned, the scheduler or nursing staff will work at replacing staff if needed, or if unable make lateral moves on or between units. d) DON/ADON will monitor compliance through monthly meeting and review of restorative nursing program. e) Correction date 10/28/18. DON/ADON is be responsible for correction and monitoring.	

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F 725	Continued From page 30	F 725		

maintain ROM and joint integrity 4-5 times weekly as directed on therapy form. Rehabilitation nursing to complete.

Review of restorative aide documentation, located in the restorative aide book, revealed a September 2018 calendar. Documentation between 9/5/18 and 9/19/18 revealed documentation of ROM on 9/6/18. All other dates were blank.

During an interview on 9/19/18, at 11:06 A.M., the assistant director of nursing-registered nurse (RN)-B stated the facility currently have 2 restorative aides, nursing assistant (NA)-D and nursing assistant (NA)-E. The restorative aides follow the recommendations for the nursing restorative program made by therapy and document the completion in the restorative books. RN-B stated when a floor aide cannot be replaced, sometimes the restorative aides get pulled to work on the floor. When asked how often this occurs, RN-B stated "I would have to ask them (NA-D and NA-E)". RN-B reviewed the September 2018 nurse restorative documentation for R57 and stated it looked like "its not being done." RN-B stated the restorative aides do the best they can with getting the ROM completed. RN-B stated the ROM is a recommendation from therapy and not physician ordered.

During an interview on 9/19/18, at 10:31 a.m., NA-D stated R57 was put on a RNP not too long ago. NA-D stated R57 is currently scheduled 4-5 times weekly for PROM. RNP stated he completed ROM one time for R57, on 9/6/18.

During a follow up interview on 9/19/18, at 11:18 a.m., NA-D stated there was currently 38

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F 725	Continued From page 31 residents on the restorative nursing program. NA-D stated he works for 4 hours on the floor, then has the remaining 4 hours to complete the restorative aide schedule. NA-D stated when there are staff call in's he gets pulled to work the floor. NA-D stated between the high case load and being pulled to the floor to work, he is unable to complete resident therapies as scheduled. During an interview on 9/19/18, at 11:33 a.m., NA-E stated when someone calls in, she works on the floor. NA-E stated she tries to make up the days on the weekend. NA-E stated over the past few weeks she was pulled from the RNP and worked on the floor several times. NA-E stated there was a lot of residents of the restorative list and cannot complete the restorative therapy for all the residents. When asked about ROM for R57, NA-E stated "I have not seen her yet myself, no." During an interview on 9/19/18, at 11:40 a.m. registered nurse (RN)-D stated the restorative aides generally work on the floor assisting with morning cares for a few hours, then go to the restorative aide department. RN-D stated the restorative aide does sometimes get pulled to work on the floor. RN-D stated call ins lately have been more of an issue and the restorative aide gets pulled to work the floor at "least a couple times a week." RN-D stated NA-E has expressed concerns with not being able to complete the therapy for all the residents on the restorative list. During an interview on 9/20/18, at 1:31 p.m. registered nurse (RN)-E stated when there are call in's, and no replacements can be found, the restorative aide is pulled to work on the floor. RN-E stated the frequency "ebbs and flows", at	F 725		

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least weekly.
R5's quarterly minimum data sets (MDS) dated 6/6/18, indicates R5 has a diagnosis of persistent vegetative state and is totally dependent on staff for all activities of daily living, and requires staff to anticipate all needs.

R5's care plan with a revision date of 9/19/18, indicated R5 was on a restorative nursing program to prevent increase in joint contractures and to maintain comfort. R5's care plan indicated passive range of motion (PROM) was to be completed three to four times a week.

R5's Care Area Assessment (CAA) dated 6/4/18, indicated R5's May restorative nursing charting was poor. R5's daily PROM was done only 7 times for the month of May 2018.

R5's Restorative Nursing Program dated 7/25/18, by the therapy department, indicated R5's goal with PROM program was to maintain joint mobility, comfort and to prevent further contractures. R5 had daily PROM to bilateral upper extremities shoulder, elbow, wrist and daily PROM to lower extremities hip, knee and ankle. The bottom of the restorative nursing program sheet had R5's daily PROM crossed off and a date of 6/11/18, changing the frequency of PROM from daily to three to four times a week.

R5's restorative treatment monthly logs indicated the days R5 received restorative nursing for the following months:
April 2018- 1 time
May- 7 times
June-10 times
July- 8 times
August- 12 times

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F 725	Continued From page 33 September 1st - 20th- 5 times. During interview on 9/20/18, at 11:19 a.m. nursing assistant and restorative nurse NA-D stated R5's restorative nursing was cut down in frequency because R5's was not getting seen five times a week. NA-D stated R5's days to be seen was decreased to three to four times a week due to not enough restorative nursing hours available. NA-D stated he was getting pulled from his restorative nursing position to help on the nursing floor. NA-D stated getting pulled is nothing new it happens all the time. NA-D stated he know R5 is not getting seen three to four times a week. NA-D further stated there are too many residents on their case load and they don't have enough staff to get the work done. During interview on 9/20/18, at 12:58 p.m. director of nursing (DON) stated The facility has to adjust cares when they have sick calls they are unable to be replaced. The DON stated the restorative aide gets pulled from their duties first as there is no place else to pull from. DON stated patient cares come first and restorative is an add on and she does not have anywhere else to pull from. The DON stated she is shorter on staffing then she would like to be and it is tough to replace staff when they call in sick.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		10/8/18

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F 732	Continued From page 34 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff postings were kept for the required 18 month timeframe. This practice had the potential to affect all 68 residents at the facility. Findings include:	F 732	a & b) No residents were affected by deficient practice. There were no complaints or grievances related to posting. c) A new process has been developed as follows:	

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F 732	Continued From page 35 During observations of the daily staff postings on 9/17/18, at 5:11 p.m. The posting was accessible to residents and visitors. The posting information was up-to-date and current. During an interview on 9/17/18, at 5:11 p.m. when asked about previous staff postings, the staffing coordinator (SC) stated the previous days staff postings were destroyed when a new staff posting was posted to the wall. During an interview on 9/17/18, at 5:22 p.m., when asked staff posting retention, the director of nursing (DON) stated "we don't keep them." The DON went on to say she was unaware of the regulation which required maintaining the staff postings for 18 months. A staffing posting policy was requested and not provided.	F 732	All of the postings for nurse staffing are now done on computer, and are saved in a file for 18 months. If any changes are made to the posting those will be added as corrections on the permanent daily sheet in the saved file by the staffing coordinator. This is in place as of 10/8/18. d) Staffing Coordinator will retain date electronically for 18 months. e)Correction date 10/8/18. DON will be responsible for ongoing compliance and prevention of reoccurrence	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		10/28/18

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§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

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F 880	Continued From page 37 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a glucometer was disinfected per manufacturers instructions for 1 of 2 residents (R20) observed during a blood glucose check. In addition, the facility failed to ensure proper hand hygiene during perineal cares for 1 of 4 residents (R57) reviewed during personal cares and failed to ensure proper hand hygiene was maintained during a medication pass for 1 of 14 residents (R9) Findings include: Glucometer During observations on 9/19/18 at 7:41 a.m. registered nurse (RN)-A entered R20's room with a blood glucose monitor. Attached to the monitor was a piece of tape with R20's name. RN-A stated residents who require routine glucose monitoring have their own glucometer. When RN-A was unable to obtain a reading from R20's glucometer, RN-A stated the glucometer was not functioning. RN-A returned the glucometer to the treatment cart. RN-A stated the night shift disinfects all glucometers daily. RN-A obtained another glucometer (Assure Platinum) from the	F 880	a) Resident R20 has shown no adverse effects from deficient practice of glucose monitor cleaning. Residents R57, R9, and R67 have had no signs or symptoms of infection related to deficient practice involving hand washing. b) All residents would be considered at risk regarding deficient practice in infection control. c) All staff will do online education on handwashing on or before 10/28/18. Nursing staff will do online education on infection control by 10/28/18. Nurses and TMA's are being re-educated on proper procedure for cleaning glucometers, most at the nursing dept meetings on 9/26/18, the remainder to be completed on or before 10/28/18. d) There will continue to be annual training in infection control and hand washing. The Director of Staff Development will complete weekly spot check that proper procedures are being	

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F 880	Continued From page 38 treatment cart. RN-A stated the glucometer was a stock glucometer. RN-A stated the stock glucometer was shared between residents and used for residents who routinely did not require glucose monitoring. After completing of the glucose monitoring in R20's room, RN-A, returned the glucometer to the treatment cart with gloved hands. RN-A placed the glucometer on a clean glove on the treatment cart, doffed her gloves, then used a hand-sani cloth to wash hands. RN-A stated the stock glucometer is cleaned with the purple topped wipes (Super-Sani Wipes) after each use. RN-A donned new gloves. RN-A wiped the glucometer with a super-sani wipe, placed the glucometer in the drawer, and removed her gloves. The surveyor immediately asked RN-A to open the drawer and observe the glucometer. The monitor was observed to be dry. When asked if the glucometer was wet or dry, RN-A stated the monitor was dry. When asked the protocol with disinfection, and the length of time the monitor needed to stay wet, RN-A stated she believed it needed to stay wet for 3 minutes. RN-A stated it was a minute since the glucometer was disinfected. When asked if the monitor stayed wet long enough, RN-A stated "I guess I should have wrapped it." RN-A placed the monitor back in the treatment cart. The manufacturer's guidelines for the Platinum Assure glucometer indicated "We suggest cleaning and disinfecting the meter between patients." The guideline directed to follow product label instructions to disinfect the meter when using a Super Sani-Cloth. The Super-Sani wipe Instructions directed "Cleaning procedure: All blood and other body	F 880	followed for 2 months. e) Correction date 10/28/18. DON will monitor for compliance.	

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fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil." "Contact time: Use second germicidal wipe to thoroughly wet surface. Allow to remain wet for two (2) minutes, let air dry."

During an interview on 9/20/18, at 2:00 p.m. the director of nursing stated to disinfect the stock glucose monitor: Take a wipe and clean off the blood and throw it away. Then use another wipe to wipe down the monitor and let it dry for 2 minutes. The DON stated she did not know the name of the wipe used or how long the monitor needed to stay wet, stating she does not clean/disinfect the monitors and was unsure of the process.

A facility Memorandum: Blood Glucose Monitoring System, dated 4/2/10, located in the Platinum Assure manufacture book directed: The RN/LPN med carts on each floor will have an additional meter that is to be kept with the tote of blood glucose monitoring supplies. "Residents who have daily or less frequent monitoring will not have their own meters and therefore the meters kept in the nursing carts MUST BE cleaned and disinfected after each use. Remember the germicidal must stay wet for 2 minutes to be effective. Please remember to wear your gloves when touching the germicidal wipes!

Hand washing perineal care
During observations on 9/18/18, at 2:28 p.m. nursing assistant (NA)-A donned gloves and used an EZ-stand to lift R57 from her wheelchair to the toilet. Prior to lowering R57 onto the toilet, NA-A lowered R57's pants and removed an incontinent brief. The brief contained urine and stool. NA-A

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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 880	Continued From page 40 opened a cupboard in R57's room and obtained a clean incontinent brief. NA-A returned to the bathroom, removed her gloves and sanitized her hands. NA-A donned new gloves. NA-A obtained several TENS cleaning wipes from a package in the bathroom. NA-A raised R57's up with the EZ stand. Stool was observed on R57's buttocks. NA-A used the TENS wipes to clean R57's bottom. NA-A did not remove her gloves. NA-A applied barrier cream to R57's bottom. NA-A Doffed gloves. NA-A did not wash her hands. NA-A pulled R57's pants up. With unwashed hands, NA-A grabbed onto the EZ-Stand, pushing the EZ-stand to the bed. NA-A touched the controller and several areas of the EZ-Stand during the transfer. NA-A lowered R57 in the bed and removed the EZ-stand harness. NA-A removed R57's shoes, assisted the residents feet up into bed, placed a pillow under R57's legs, covered R57 with a blanket, and attached a call light to the blanket. NA-A touched the controller on the bed, lowering R57's bed to a low position. NA-A donned gloves, cleaned the toilet seat with a TENS wipe, throwing the wipe in the garbage after use. NA-A removed the garbage bag, placing a new bag in the bin. NA-A doffed gloves and washed her hands. NA-A removed the EZ-stand from R57's room without cleaning or disinfecting. During an interview on 9/18/18, at 1:52 p.m., NA-A stated hands are washed before and after cares. NA-A stated gloves are worn during perineal cares. The gloves are removed and hands are washed after cleaning stool. When asked why she did not wash her hands after contact with stool, NA-A stated "I was afraid with way she was standing on the EZ stand."	F 880		

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F 880	Continued From page 41 During an interview on 9/20/18, at 1:57 p.m. the director of nursing (DON) stated staff wash hands, wear gloves, provide cares, remove the gloves, and wash hands. Re-glove if needed. The facility's policy Glove Use dated 7/06 indicated gloves are to be used when it is likely that hands will come in contact with blood, bloody fluids, or other potentially infectious material. Wash hands after removing gloves. Gloves do not replace hand washing. Hand washing during medication pass During an observation of a medication pass on 9/19/18, at 11:56 a.m. licensed practical nurse (LPN)-A was working on 2nd floor medication cart. LPN-A initially washed his hands before starting his medication pass. LPN-A washed hands before putting on gloves in R9's room before cleaning R9's finger with alcohol to check glucose reading. LPN- A cleaned R9's arm with alcohol before dialing up and giving the insulin injection. LPN-A took off gloves then left the room, without using hand sanitizer or hand washing, LPN-A went back to medication cart and put the supplies away and passed off cart keys to another nurse. LPN-A was working on a computer, then went to treatment cart and pulled out a glucometer. LPN-A did not used hand sanitizer or wash hands. LPN-A went to the out side of R67's room, and grabbed a gown and pair of gloves from the isolation cart as R67 is in an isolation room. LPN-A entered the room obtained a glucose reading, removed gown and gloves and disposed of them. R67's record indicated R67 had MRSA (Methicillin resistant staphylococcus aureus, infection). MRSA was localized to a wound in right lower leg. During observation the wound was observed to be covered with a dressing and ace wrap and pants.	F 880		

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F 880	Continued From page 42 LPN-A left R67's room without washing hands or using hand sanitizer, went back to the medication cart and put R67's personal glucometer away in a separate compartment of the medication cart. During interview on 9/19/18, immediately following the observation, before starting his third medication pass LPN-A was asked if he washed his hands, LPN-A immediately washed hands stated he had not not wash hands or use hand sanitizer after leaving R9's room following R9's medication pass in that room. LPN-A further stated he did not wash hand or use hand sanitizer either before or after leaving R67's room who was on isolation precautions. LPN-A stated he was so busy and nervous concentrating on everything else that he forgot hand hygiene. A facility police entitled Hand Washing identifies handwashing as being the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from the spread of infection.	F 880		

Minnesota Department of Health

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On September 17, 18, 19 and 20 , surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staffing was available in order to implement the restorative nursing program for 2 of 2 residents (R57, R5) reviewed for range of motion. This had the potential to affect all 38 residents receiving restorative nursing services. Findings include: R57's admission Minimum Data Set (MDS) dated 8/23/18, indicated severe cognitive impairment. R57 received extensive assistance for bed mobility, transfers, dressing and personal hygiene. R57 had impairment bilaterally of lower extremities. Physical therapy started on 8/20/18, and was not currently on a restorative nursing program.	2 800	Corrected on or before 10/28/18	10/28/18

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2 800	Continued From page 3 R57's Physical therapy Daily Treatment note, dated 9/5/18, indicated passive range of motion (PROM-staff assisting with moving joints) was completed to bilateral ankle, knee and hip. R57's put on a restorative nursing program (RNP) for PROM. Nurse manager and restorative staff updated/educated. "form turned into appropriate staff." R57's care plan, dated 9/5/18, indicated R57's care plan was updated to include an individualized restorative nursing program to maintain ROM and joint integrity 4-5 times weekly as directed on therapy form. Rehabilitation nursing to complete. Review of restorative aide documentation, located in the restorative aide book, revealed a September 2018 calendar. Documentation between 9/5/18 and 9/19/18 revealed documentation of ROM on 9/6/18. All other dates were blank. During an interview on 9/19/18, at 11:06 A.M., the assistant director of nursing-registered nurse (RN)-B stated the facility currently have 2 restorative aides, nursing assistant (NA)-D and nursing assistant (NA)-E. The restorative aides follow the recommendations for the nursing restorative program made by therapy and document the completion in the restorative books. RN-B stated when a floor aide cannot be replaced, sometimes the restorative aides get pulled to work on the floor. When asked how often this occurs, RN-B stated "I would have to ask them (NA-D and NA-E)". RN-B reviewed the September 2018 nurse restorative documentation for R57 and stated it looked like "its not being done." RN-B stated the restorative aides do the	2 800		

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2 800	Continued From page 4	2 800		

best they can with getting the ROM completed. RN-B stated the ROM is a recommendation from therapy and not physician ordered.

During an interview on 9/19/18, at 10:31 a.m., NA-D stated R57 was put on a RNP not too long ago. NA-D stated R57 is currently scheduled 4-5 times weekly for PROM. RNP stated he completed ROM one time for R57, on 9/6/18.

During a follow up interview on 9/19/18, at 11:18 a.m., NA-D stated there was currently 38 residents on the restorative nursing program. NA-D stated he works for 4 hours on the floor, then has the remaining 4 hours to complete the restorative aide schedule. NA-D stated when there are staff call in's he gets pulled to work the floor. NA-D stated between the high case load and being pulled to the floor to work, he is unable to complete resident therapies as scheduled.

During an interview on 9/19/18, at 11:33 a.m., NA-E stated when someone calls in, she works on the floor. NA-E stated she tries to make up the days on the weekend. NA-E stated over the past few weeks she was pulled from the RNP and worked on the floor several times. NA-E stated there was a lot of residents of the restorative list and cannot complete the restorative therapy for all the residents. When asked about ROM for R57, NA-E stated "I have not seen her yet myself, no."

During an interview on 9/19/18, at 11:40 a.m. registered nurse (RN)-D stated the restorative aides generally work on the floor assisting with morning cares for a few hours, then go to the restorative aide department. RN-D stated the restorative aide does sometimes get pulled to work on the floor. RN-D stated call ins lately have

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2 800	Continued From page 5	2 800		

been more of an issue and the restorative aide gets pulled to work the floor at "least a couple times a week." RN-D stated NA-E has expressed concerns with not being able to complete the therapy for all the residents on the restorative list.

During an interview on 9/20/18, at 1:31 p.m. registered nurse (RN)-E stated when there are call in's, and no replacements can be found, the restorative aide is pulled to work on the floor. RN-E stated the frequency "ebbs and flows", at least weekly.

R5's quarterly minimum data sets (MDS) dated 6/6/18, indicates R5 has a diagnosis of persistent vegetative state and is totally dependent on staff for all activities of daily living, and requires staff to anticipate all needs.

R5's care plan with a revision date of 9/19/18, indicated R5 was on a restorative nursing program to prevent increase in joint contractures and to maintain comfort. R5's care plan indicated passive range of motion (PROM) was to be completed three to four times a week.

R5's Care Area Assessment (CAA) dated 6/4/18, indicated R5's May restorative nursing charting was poor. R5's daily PROM was done only 7 times for the month of May 2018.

R5's Restorative Nursing Program dated 7/25/18, by the therapy department, indicated R5's goal with PROM program was to maintain joint mobility, comfort and to prevent further contractures. R5 had daily PROM to bilateral upper extremities shoulder, elbow, wrist and daily PROM to lower extremities hip, knee and ankle. The bottom of the restorative nursing program sheet had R5's daily PROM crossed off and a

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2 800	Continued From page 6	2 800		

Continued From page 6

date of 6/11/18, changing the frequency of PROM from daily to three to four times a week.

R5's restorative treatment monthly logs indicated the days R5 received restorative nursing for the following months:
April 2018- 1 time
May- 7 times
June-10 times
July- 8 times
August- 12 times
September 1st - 20th- 5 times.

During interview on 9/20/18, at 11:19 a.m. nursing assistant and restorative nurse NA-D stated R5's restorative nursing was cut down in frequency because R5's was not getting seen five times a week. NA-D stated R5's days to be seen was decreased to three to four times a week due to not enough restorative nursing hours available. NA-D stated he was getting pulled from his restorative nursing position to help on the nursing floor. NA-D stated getting pulled is nothing new it happens all the time. NA-D stated he know R5 is not getting seen three to four times a week. NA-D further stated there are too many residents on their case load and they don't have enough staff to get the work done.

During interview on 9/20/18, at 12:58 p.m. director of nursing (DON) stated The facility has to adjust cares when they have sick calls they are unable to be replaced. The DON stated the restorative aide gets pulled from their duties first as there is no place else to pull from. DON stated patient cares come first and restorative is an add on and she does not have anywhere else to pull from. The DON stated she is shorter on staffing then she would like to be and it is tough to replace staff when they call in sick.

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2 800	Continued From page 7 SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for staffing and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance with staffing coverage and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure continuous oxygen therapy was administered according to the care plan for 1 of 1 residents (R28) observed	2 830	Corrected on or before 10/28/18	10/28/18

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2 830	Continued From page 8 receiving oxygen therapy. In addition R28's current physician orders were lacking orders for oxygen. Findings include: R28's significant change Minimum Data Sets (MDS) dated 8/3/18, indicated R28 is cognitively impaired, required extensive assist with all activities of daily living, and had diagnoses including chronic obstructive pulmonary disease (COPD), pulmonary emphysema, pneumonia and Parkinson's disease. R28 has shortness of breath, trouble breathing with exertion and when at rest and is on continuous oxygen therapy. R 28's care plan date last reviewed 7/31/18, indicated respiratory impairment related to his COPD and pulmonary emphysema and required continuous oxygen to maintain therapeutic oxygen saturations above 90 percent. The care plan also indicated R28 was on continuous oxygen per nasal cannula at 2/liters per minute. R28's Care Area Assessment indicates R28 is oxygen dependent at 2 liters per minute. R28's treatment administration record dated month of September 2018, indicated R28 required staff to check portable oxygen tank every two hours and as needed to maintain continuous supply of oxygen at 2 liters per minute by nasal cannula. R28's physican order dated 8/20/18 through 9/20/18, was lacking orders for oxygen. During observation on 9/17/18, at 1:43 p.m. R28 was up with oxygen on at 2 liter per minute walking in hallway with his walker and two staff	2 830		

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2 830	Continued From page 9	2 830		

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assist with ambulating. R28 was short of breath when he returned to his room and his oxygen saturations were 87 percent due to his exertion with walking. R28 rested for two minutes and his oxygen saturations came back up above 90.

During observation on 9/17/18, at 4:47 p.m. R28's portable oxygen tank displayed being in the red zone on the regulator, indicating oxygen tank was empty, and R28 was not receiving any oxygen through his nasal cannula.

During interview on 9/17/18, at 4:47 p.m. registered nurse (RN)-D stated R28's tank was empty and said he was not receiving any oxygen through his nasal cannula. R28's respiratory rate was 24 breaths per minute and his breathing was labored when R28 said he could "use a fill again". RN-D left to get a new full portable tank of oxygen for R28.

During interview on 9/20/18, at 10:27 a.m. nursing assistant (NA)-F stated R28 does not have an oxygen concentrator in his room, only has the portable oxygen. NA-F stated she checks the residents oxygen tanks for level of oxygen left in the tank when she arrives at work, when giving cares and every two hours there after during her working shift. NA-F stated she is not sure the last time R28's oxygen level in tank was checked however, stated she was sure another nurse checked it since she last checked at 8:00 a.m. NA-F was unable to say at what times the tank was checked. NA-F stated that R28 yells down the hallway that he needs oxygen if his oxygen runs out.

During interview on 9/20/18, at 10:36 NA-G stated she always checks the portable oxygen levels in the tanks when dealing with the residents when

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2 830	Continued From page 10	2 830		

they are at breakfast or lunch. NA-G stated she is not sure how often the oxygen levels in the tank are checked but she will find out. NA-G stated it is every two hours when portable oxygen tanks are checked. NA-G stated she keeps track of when tanks need to be checked in her head, that she does not write it down and she will ask other NA's when they checked the portable oxygen tanks.

During interview on 9/20/18, at 10:43 a.m. NA-H stated she checks the portable oxygen tanks when she gets the residents up in the morning and before every meal. NA-G stated we monitor as much as we can so the tanks do not go empty. NA-G stated she is not sure what time R28's tank was last checked for oxygen level.

During interview on 9/20/18, at 10:48 a.m. RN-A stated the portable oxygen tanks are checked every two hours and are document in the computer when the tank was checked. RN-A stated usually the person checking the oxygen levels in the tank is the one who gets them up in the morning or brings them back to their room. RN-A stated R28 will tell the nurses when he is out of oxygen.

During interview on 9/20/18, at 10:54 a.m. RN-C stated R28's oxygen level in tank gets checked every 2 hours. RN-C stated there is a treatment record in the medication administration record and the nurses and nursing aides are to document the times the tanks are checked. RN-C stated the nurses may get busy and don't check the tanks or don't document the tanks were checked at times.

A facility policy entitled Oxygen Use undated indicates oxygen will be administered according to provider orders.

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2 830	Continued From page 11 SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures and educate staff to ensure process for changing portable oxygen tanks is followed. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide restorative nursing services to maintain mobility and range of motion	2 895	Corrected on or before 10/28/18	10/28/18

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for 2 of 2 residents (R57, R5) reviewed for range of motion. This had the potential to affect all 38 residents receiving restorative nursing services.

Findings include:

R57's admission Minimum Data Set (MDS) dated 8/23/18, indicated severe cognitive impairment. R57 received extensive assistance for bed mobility, transfers, dressing and personal hygiene. R57 had impairment bilaterally of lower extremities. Physical therapy started on 8/20/18, and was not currently on a restorative nursing program.

R57's Physical therapy Daily Treatment note, dated 9/5/18, indicated passive range of motion (PROM-staff assisting with moving joints) was completed to bilateral ankle, knee and hip. R57 put on a restorative nursing program (RNP) for PROM. Nurse manager and restorative staff updated/educated. "form turned into appropriate staff."

R57's Therapy Department form for Restorative Nursing Program, dated 9/5/18, directed lower body PROM seated. See handout provided. Encourage active ROM with exercises 4-5 times weekly. Handout included directions for PROM 15-20 repetitions each leg.

R57's care plan, dated 9/5/18, indicated R57's care plan was updated to include an individualized restorative nursing program to maintain ROM and joint integrity 4-5 times weekly as directed on therapy form. Rehabilitation nursing to complete.

Review of restorative aide documentation, located in the restorative aide book, revealed a

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September 2018 calendar. Documentation between 9/5/18 and 9/19/18 revealed documentation of ROM on 9/6/18. All other dates were blank.

During an interview on 9/19/18, at 11:06 A.M., the assistant director of nursing-registered nurse (RN)-B stated the facility currently have 2 restorative aides, nursing assistant (NA)-D and nursing assistant NA-E. The restorative aides follow the recommendations for the nursing restorative program made by therapy and document the completion in the restorative books. RN-B stated when a floor aide cannot be replaced, sometimes the restorative aides get pulled to work on the floor. When asked how often this occurs, RN-B stated "I would have to ask them (NA-D and NA-E)". RN-B reviewed the September 2018 nurse restorative documentation for R57 and stated it looked like "its not being done." RN-B stated the restorative aides do the best they can with getting the ROM completed. RN-B stated the ROM is a recommendation from therapy and not physician ordered.

During an interview on 9/19/18, at 10:31 a.m., NA-D stated R57 was put on a RNP not too long ago. NA-D stated R57 is currently scheduled 4-5 times weekly for PROM. NA-D stated he completed ROM one time for R57, on 9/6/18.

During a follow up interview on 9/19/18, at 11:18 a.m., NA-D stated there was currently 38 residents on the restorative nursing program. NA-D stated he works for 4 hours on the floor, then has the remaining 4 hours to complete the restorative aide schedule. NA-D stated when there are staff call in's he gets pulled to work the floor. NA-D stated between the high case load and being pulled to the floor to work, he is unable

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to complete resident therapies as scheduled.

During an interview on 9/19/18, at 11:33 a.m., NA-E stated when someone calls in, she works on the floor. NA-E stated she tries to make up the days on the weekend. NA-E stated over the past few weeks she was pulled from the RNP and worked on the floor several times. NA-E stated there was a lot of residents of the restorative list and cannot complete the restorative therapy for all the residents. When asked about ROM for R57, NA-E stated "I have not seen her yet myself, no."

During an interview on 9/19/18, at 12:18 p.m. physical therapy assistant (PTA)-C stated R57 was discharged to a restorative nursing program on 9/6/18. The recommendations were for PROM 4-5 times weekly. PTA-C stated the frequency of ROM is important to keep R57's joints moving. PTA-C completed a screening to evaluate for any changes in ROM since 9/6/18. PTA-C stated R57's ROM remained unchanged.

R5's quarterly minimum data sets (MDS) dated 6/6/18, indicates R5 has a diagnosis of persistent vegetative state and is totally dependent on staff for all activities of daily living, and requires staff to anticipate all needs.

R5's care plan with a revision date of 9/19/18, indicated R5 was on a restorative nursing program to prevent increase in joint contractures and to maintain comfort. R5's passive range of motion (PROM) included left hip flexion, right and left knee flexion, bilateral hip abduction, bilateral ankle flexion, bilateral shoulder flexion, bilateral elbow flexion and bilateral wrist flexion three to four times a week.

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R5's Care Area Assessment (CAA) dated 6/4/18, indicated R5's May restorative nursing charting was poor. R5's daily PROM was done only 7 times for the month of May 2018. The CAA indicated no change to R5's range of motion and no decline, no referrals needed, and to continue with the current plan of care.

R5's Restorative Nursing Program dated 7/25/18, by the therapy department, indicated R5's goal with PROM program was to maintain joint mobility, comfort and to prevent further contractures. R5 had daily PROM to bilateral upper extremities shoulder, elbow, wrist and daily PROM to lower extremities hip, knee and ankle. The bottom of the restorative nursing program sheet had R5's daily PROM crossed off and a date of 6/11/18, changing the frequency of PROM from daily to three to four times a week.

R5's nursing assistant care sheets undated, did not direct staff to complete R5's PROM.

R5's restorative treatment monthly logs indicated the days R5 received restorative nursing for the following months:
April 2018- 1 time
May- 7 times
June-10 times
July- 8 times
August- 12 times
September 1st - 20th- 5 times.

During interview on 9/20/18, at 11:19 a.m. nursing assistant and restorative nurse NA-D stated R5's restorative nursing was cut down in frequency because R5's was not getting seen five times a week. NA-D stated R5's days to be seen was decreased to three to four times a week due to not enough restorative nursing hours available.

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2 895	Continued From page 16 NA-D stated he was getting pulled from his restorative nursing position to help on the nursing floor. NA-D stated getting pulled is nothing new it happens all the time. NA-D stated he know R5 is not getting seen three to four times a week. NA-D further stated there are too many residents on their case load and they don't have enough staff to get the work done. During interview on 9/20/18, at 12:20 p.m. RN-B stated restorative nursing is a recommendation from therapy, it is not an order. RN-B stated if facility is unable to replace sick calls for nursing on the floor, they do pull the restorative aide to help out until cares are completed. RN-B stated she know restorative nursing has been "lagging". RN-B stated R5 has not declined with his range of motion, he has been here for a long time and his contractures do not look any worse. RN-B stated she is not saying restorative nursing should not be done, just that R5 has not had a decline in his range of motion. RN-B further stated she has talked to the therapy staff and knows the restorative program is getting bigger and bigger and they don't have the staff to have the restorative program. RN-B stated that all we have ever had is one restorative staff, and one is not enough. During interview on 9/20/18, at 12:58 p.m. director of nursing (DON) stated The facility has to adjust cares when they have sick calls they are unable to be replaced. The DON stated the restorative aide gets pulled from their duties first as there is no place else to pull from. DON stated patient cares come first and restorative is an add on and she does not have anywhere else to pull from. The DON stated she is shorter on staffing then she would like to be and it is tough to replace staff when they call in sick.	2 895		

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During interview on 9/20/18, at 1:44 p.m. Physical therapy assistant (PTA)-A stated it would be good for nursing to follow the recommendations made by therapy so the residents are less likely to decline.

A policy titled, Restorative Nursing and Rehabilitative Program identified it was a program in place to assist residents in attaining or maintaining their highest level of function, maintain dignity and self-worth, and prevent complications of chronic conditions and that the service is provided seven days a week.

The facility's policy Restorative Nursing and Rehabilitative Program, dated 8/16/11, indicated nursing or therapy will identify residents in need of restorative nursing/rehabilitative program. The therapist will develop a program if appropriate and communicate the program to the restorative aides and the RN case manager. Each plan will have individualized goals and the identified tasks to be completed. A schedule will be developed with the oversight of the therapy department. The restorative aide will document on the flow sheet the number of minutes for each task completed.

SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for range of motion and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty one

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2 895	Continued From page 18 (21) days	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions to prevent and treat pressure ulcers were implemented for 1 of 3 residents (R57) reviewed for pressure ulcers. The findings include: R57's admission Minimum Data Set (MDS), dated 8/23/18 identified 57's was severely cognitively impaired. R57 required extensive assist for bed mobility, transfers, dressing, and toileting. R57 was at risk for pressure ulcers. Interventions included a pressure reducing device in bed and	2 900	Corrected on or before 10/28/18	10/28/18

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chair.

R57's care plan, dated 9/4/18, indicated R57 was at risk for pressure ulcers, skin was intact. Interventions to maintain intact skin integrity included to turn/reposition/offload R57 approximately every 2 hours. Additional interventions included a pressure reducing mattress. The care plan lacked direction for the use of a pressure reducing wheelchair cushion.

R57's progress note dated 9/8/18, indicated R57 had developed a 0.9 cm x 0.3 cm open area to the coccyx. Tegaderm foam dressing applied to prevent friction and sheer. Staff directed to turn R57 from side to side. Although a pressure reducing wheelchair cushion was identified as a previous intervention, the note indicated "Wheelchair cushion added to wheelchair with Dycem (non-slip mat)".

R57's progress note dated 9/10/18, identified registered nurse (RN)-C assessed R57's coccyx wound. RN-C assessed the wound as a stage II pressure ulcer (blistering, cracking, or abrasion to the skin). The pressure ulcer measured 0.4 cm x 0.5 cm and had 100% epithelial tissue present to wound bed. Interventions included Tegaderm dressing every 3 days and as needed to protect area for pressure and shearing, off loading "at least" every 2 hours, laying down in the afternoon with side to side repositioning in bed, and cushion in wheelchair.

R57's physician orders identified a 9/10/18 nursing order to monitor R57's coccyx every shift and change the Tegaderm foam dressing every 3-7 days. A 9/15/18 nursing order to turn R57 from side to side when in bed to keep pressure off coccyx.

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Review of R57's care plan on 9/18/18 lacked revision to include the development of the pressure ulcer and updated interventions, including the change of offloading from approximately every 2 hours to at least every 2 hours as assessed on 9/10/18.

During continuous observations on 9/18/18, at 10:57 a.m. R57 was in the dining room attending a group activity. R57 was sitting in a wheelchair. R57 was sitting on a black cushion. At 11:58 p.m. group ended. Staff did not offload or offer repositioning or toileting. R57 at a dining room table awaiting meal. At 12:36 p.m. R57 received meal and staff assisted with meal. At 1:33 p.m. nursing assistant (NA)-A stated to R57 "lets go to the bathroom." NA-A assisted R57 to the toilet using the stand lift. After NA-A removed R57's incontinent brief, NA-A stated R57 was incontinent of stool and urine. Observations to R57's coccyx revealed a foam dressing dated 9/15/18. R57's coccyx and buttocks had no redness or discoloration. After completing toileting and providing incontinence care, NA-A assisted R57 to bed using the stand lift. No offloading or repositioning was provided or offered during the 2 1/2 hours of constant observations.

During an interview on 9/18/18, at 1:52 p.m. when asked about turning/repositioning/offloading, NA-A stated it's "suppose to be every 2 hours." When asked the last time R57 was repositioned, NA-A stated one of the other nursing assistants toileted R57 prior to lunch, but did not know which one. NA-A went on to say 3 nursing assistants were working. NA-A identified the other 2 nursing assistants as nursing assistant NA-B and nursing assistant NA-C. NA-A stated residents are not

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assigned to a specific nursing assistant and duties are shared between all 3 nursing assistants. When asked how she knows when a resident was repositioned, NA-A stated repositioning times are documented on the repositioning board. NA-A reviewed the repositioning board, located at the nursing station. The repositioning board lacked documentation of repositioning for 9/18/18. NA-A stated the last time repositioning was documented was the previous evening, 9/17/18. NA-A stated the last time she provided cares, including repositioning for R57 was approximately 7:30 a.m., when she assisted R57 with morning cares and getting R57 up in her wheelchair.

During an interview on 9/18/18, at 2:07 p.m. NA-C stated nursing assistants are not assigned to specific residents. NA-C stated R57 is repositioned every 2 hours. When asked how she knows when R57 was repositioned, NA-C stated she communicates with the other nursing assistants throughout the day. NA-C stated she had not assisted R57 with cares on 9/18/18, including repositioning.

During an interview on 9/18/18, at 2:12 p.m. NA-B stated staff are not assigned residents. When asked how she knows when a resident was repositioned or toileted, NA-B stated "we usually ask the other aides." NA-B stated the nursing assistants are trying to get in the habit of documenting repositioning on the clip board, but that does not always happen. When asked about the repositioning board for 9/18/18, NA-B looked at the board and stated "one was not set up today." NA-B stated she had not assisted R57 with cares on 9/18/18, including repositioning.

During an interview on 9/19/18, at 1:10 p.m.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 22	2 900		

registered nurse (RN)-C stated upon admission, R57 was assessed to be at risk for pressure ulcers. RN-C stated all mattresses are pressure reducing. RN-C stated R57 developed a stage II coccyx pressure ulcer on 9/8/18. RN-C stated the intervention of a pressure reducing chair cushion was not initiated until after the pressure ulcer developed on 9/8/18, when the nurse who identified the pressure ulcer initiated a wheelchair cushion. RN-C stated a new intervention of turning from side to side in bed was also initiated on 9/8/18. RN-C stated she updated R57's care plan to include the development of the pressure ulcer and new interventions; however, after reviewing R57's care plan RN-C stated the care plan was not updated. RN-C stated nursing assistants are not assigned to residents during the day. RN-C stated staff are to refer to the turning and repositioning sheet to determine when a resident needs to be offloaded/ repositioned. RN-C stated the day shift was not very good about documenting on the form, but have been getting better at it.

During an interview on 9/20/18, at 1:55 p.m., the director of nursing (DON) stated staff are to implement interventions as assessed.

The facility's policy Prevention of Pressure Ulcers, revised January 2002 directed a resident's risk factor is assessed on admission, quarterly and with a significant change in status using the risk scale identified by protocol. Risk factor preventive actions include for a person in a chair to change position at least every 2 hours and use a foam, get or air cushion as indicated to relieve pressure. Persons confined to chairs should be repositioned at least every 2 hours. Persons confined to chairs who are unable to shift their own weight may need repositioning

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	00634	A. BUILDING: ______ B. WING ______	09/20/2018

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2 900	Continued From page 23 more frequently. The facility's policy Care Planning, revised 8/8/17, directed the RN unit manager will ensure that each plan of care includes information related to the resident's treatment, wellness, and recovery. The RN unit manager will ensure periodic review of the care plan based on resident's individual needs, which include when warranted by changes in resident's medical condition. When changes in goals, objectives, or interventions are identified. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		10/28/18

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21375	Continued From page 24 by: Based on observation, interview, and document review, the facility failed to ensure a glucometer was disinfected per manufacturers instructions for 1 of 2 residents (R20) observed during a blood glucose check. In addition, the facility failed to ensure proper hand hygiene during perineal cares for 1 of 4 residents (R57) reviewed during personal cares and failed to ensure proper hand hygiene was maintained during a medication pass for 1 of 14 residents (R9) Findings include: Glucometer During observations on 9/19/18 at 7:41 a.m. registered nurse (RN)-A entered R20's room with a blood glucose monitor. Attached to the monitor was a piece of tape with R20's name. RN-A stated residents who require routine glucose monitoring have their own glucometer. When RN-A was unable to obtain a reading from R20's glucometer, RN-A stated the glucometer was not functioning. RN-A returned the glucometer to the treatment cart. RN-A stated the night shift disinfects all glucometers daily. RN-A obtained another glucometer (Assure Platinum) from the treatment cart. RN-A stated the glucometer was a stock glucometer. RN-A stated the stock glucometer was shared between residents and used for residents who routinely did not require glucose monitoring. After completing of the glucose monitoring in R20's room, RN-A, returned the glucometer to the treatment cart with gloved hands. RN-A placed the glucometer on a clean glove on the treatment cart, doffed her gloves, then used a hand-sani cloth to wash hands. RN-A stated the stock glucometer is cleaned with the purple topped wipes (Super-Sani Wipes) after each use. RN-A	21375	Corrected on or before 10/28/18	

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donned new gloves. RN-A wiped the glucometer with a super-sani wipe, placed the glucometer in the drawer, and removed her gloves. The surveyor immediately asked RN-A to open the drawer and observe the glucometer. The monitor was observed to be dry. When asked if the glucometer was wet or dry, RN-A stated the monitor was dry. When asked the protocol with disinfection, and the length of time the monitor needed to stay wet, RN-A stated she believed it needed to stay wet for 3 minutes. RN-A stated it was a minute since the glucometer was disinfected. When asked if the monitor stayed wet long enough, RN-A stated "I guess I should have wrapped it." RN-A placed the monitor back in the treatment cart.

The manufacturer's guidelines for the Platinum Assure glucometer indicated "We suggest cleaning and disinfecting the meter between patients." The guideline directed to follow product label instructions to disinfect the meter when using a Super Sani-Cloth.

The Super-Sani wipe Instructions directed "Cleaning procedure: All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil." "Contact time: Use second germicidal wipe to thoroughly wet surface. Allow to remain wet for two (2) minutes, let air dry."

During an interview on 9/20/18, at 2:00 p.m. the director of nursing stated to disinfect the stock glucose monitor: Take a wipe and clean off the blood and throw it away. Then use another wipe to wipe down the monitor and let it dry for 2 minutes. The DON stated she did not know the name of the wipe used or how long the monitor

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needed to stay wet, stating she does not clean/disinfect the monitors and was unsure of the process.

A facility Memorandum: Blood Glucose Monitoring System, dated 4/2/10, located in the Platinum Assure manufacture book directed: The RN/LPN med carts on each floor will have an additional meter that is to be kept with the tote of blood glucose monitoring supplies. "Residents who have daily or less frequent monitoring will not have their own meters and therefore the meters kept in the nursing carts MUST BE cleaned and disinfected after each use. Remember the germicidal must stay wet for 2 minutes to be effective. Please remember to wear your gloves when touching the germicidal wipes!

Hand washing perineal care
During observations on 9/18/18, at 2:28 p.m. nursing assistant (NA)-A donned gloves and used an EZ-stand to lift R57 from her wheelchair to the toilet. Prior to lowering R57 onto the toilet, NA-A lowered R57's pants and removed an incontinent brief. The brief contained urine and stool. NA-A opened a cupboard in R57's room and obtained a clean incontinent brief. NA-A returned to the bathroom, removed her gloves and sanitized her hands. NA-A donned new gloves. NA-A obtained several TENS cleaning wipes from a package in the bathroom. NA-A raised R57's up with the EZ stand. Stool was observed on R57's buttocks. NA-A used the TENS wipes to clean R57's bottom. NA-A did not remove her gloves. NA-A applied barrier cream to R57's bottom. NA-A Doffed gloves. NA-A did not wash her hands. NA-A pulled R57's pants up. With unwashed hands, NA-A grabbed onto the EZ-Stand, pushing the EZ-stand to the bed. NA-A touched the controller and several areas of the EZ-Stand

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during the transfer. NA-A lowered R57 in the bed and removed the EZ-stand harness. NA-A removed R57's shoes, assisted the residents feet up into bed, placed a pillow under R57's legs, covered R57 with a blanket, and attached a call light to the blanket. NA-A touched the controller on the bed, lowering R57's bed to a low position. NA-A donned gloves, cleaned the toilet seat with a TENS wipe, throwing the wipe in the garbage after use. NA-A removed the garbage bag, placing a new bag in the bin. NA-A doffed gloves and washed her hands. NA-A removed the EZ-stand from R57's room without cleaning or disinfecting.

During an interview on 9/18/18, at 1:52 p.m., NA-A stated hands are washed before and after cares. NA-A stated gloves are worn during perineal cares. The gloves are removed and hands are washed after cleaning stool. When asked why she did not wash her hands after contact with stool, NA-A stated "I was afraid with way she was standing on the EZ stand."

During an interview on 9/20/18, at 1:57 p.m. the director of nursing (DON) stated staff wash hands, wear gloves, provide cares, remove the gloves, and wash hands. Re-glove if needed.

The facility's policy Glove Use dated 7/06 indicated gloves are to be used when it is likely that hands will come in contact with blood, bloody fluids, or other potentially infectious material. Wash hands after removing gloves. Gloves do not replace hand washing.
Hand washing during medication pass
During an observation of a medication pass on 9/19/18, at 11:56 a.m. licensed practical nurse (LPN)-A was working on 2nd floor medication cart. LPN-A initially washed his hands before

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21375	Continued From page 28 starting his medication pass. LPN-A washed hands before putting on gloves in R9's room before cleaning R9's finger with alcohol to check glucose reading. LPN- A cleaned R9's arm with alcohol before dialing up and giving the insulin injection. LPN-A took off gloves then left the room, without using hand sanitizer or hand washing, LPN-A went back to medication cart and put the supplies away and passed off cart keys to another nurse. LPN-A was working on a computer, then went to treatment cart and pulled out a glucometer. LPN-A did not used hand sanitizer or wash hands. LPN-A went to the out side of R67's room, and grabbed a gown and pair of gloves from the isolation cart as R67 is in an isolation room. LPN-A entered the room obtained a glucose reading, removed gown and gloves and disposed of them. R67's record indicated R67 had MRSA (Methicillin resistant staphylococcus aureus, infection). MRSA was localized to a wound in right lower leg. During observation the wound was observed to be covered with a dressing and ace wrap and pants. LPN-A left R67's room without washing hands or using hand sanitizer, went back to the medication cart and put R67's personal glucometer away in a separate compartment of the medication cart. During interview on 9/19/18, immediately following the observation, before starting his third medication pass LPN-A was asked if he washed his hands, LPN-A immediately washed hands stated he had not not wash hands or use hand sanitizer after leaving R9's room following R9's medication pass in that room. LPN-A further stated he did not wash hand or use hand sanitizer either before or after leaving R67's room who was on isolation precautions. LPN-A stated he was so busy and nervous concentrating on everything else that he forgot hand hygiene.	21375		

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21375	Continued From page 29 A facility police entitled Hand Washing identifies handwashing as being the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from the spread of infection. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policy and procedure related to cleaning and disinfecting equipment and handwashing and could provide education to ensure understanding. Also monitor for compliance and bring the audit information to QAPI for review. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure an allegations of	21995	Corrected on or before 10/28/18	10/28/18

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21995	Continued From page 30	21995		

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misappropriation of missing money was reported to the State Agency (SA) and the administrator for 1 of 1 resident (R26) reviewed for allegations of missing money.

Findings include:

R26's resident face sheet undated indicated R26's diagnoses included diabetes mellitus. R26's annual Minimum Data Set (MDS) indicated R26 was cognitively intact and required the assistance of one staff with activities of daily living (ADL).

During an interview on 9/17/18, at 6:20 p.m. R26 stated $40.00 was missing from R26's room. R26 stated the five dollars was for the collection plate at church and the rest was in my wallet. R26 stated the nurses were told and I did not get my money returned. R26 did not want to file a police report.

An interview on 9/18/18, at 1:58 p.m. the director of social service (DSS) stated if there were problems staff will fill out a grievance form, missing items form and give it to me. DSS stated R26's family did notify them of the missing money. DSS stated the SA was not notified because DSS could not verify R26 had any money in R26's room. DSS stated we did not know if the money existed.

An interview on 9/20/18, at 10:15 a.m. with the director of nursing (DON) stated abuse training is conducted annually on the computer for the staff and when hired. The DON state theft is abuse and should be reported to the SA immediately or in two hour window. The DON stated if a resident were missing $40.00 it should be reported to the SA.

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An interview on 9/20/18, at 10:26 a.m. with the assistant director of nursing (ADON) stated we do not need to report to the SA if a resident is missing money. The ADON stated residents are offered a lock box for valuables or they can put them in the business office, the residents are made aware that they are at their own risk if they do not lock up their valuables.

An interview on 9/20/18, at 11:11 a.m. the administrator stated they report to the SA maltreatment, abuse, significant injuries, bruising of unknown origin, resident to resident altercations and criminal things like missing money. The administrator stated staff are required to report these things to me also. The administrator stated a log was kept of the incidents reported to the administrator and no missing money allegations had been reported in August, September, or October 2017. The administrator stated he should have been made aware of this immediately and should have told law enforcement too.

A Grievance and Missing Items Form dated 10/3/17, indicated R26 went to church and R26's family closed the door to the room. R26 noticed on 10/3/17 that $40.00 was missing from the wallet that was kept in the dresser by the door. Also the form indicated the administrator needed to be notified immediately of possible vulnerable adult/abuse/maltreatment. There was no date or time the administrator was notified.

A review of the facilities OHFC (office of health facility complaints) log did not indicate any missing money allegations were reported to the SA from the facility.

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The facility policy Abuse Prevention and Vulnerable Adult Procedure undated, indicated all residents residing in the facility will be protected from maltreatment. The facility requires all suspected maltreatment be reported promptly. The Professional or Professional's delegate, while engaged in the care of vulnerable adults will make sure that a report is made out, that the internal investigation begins immediately, the appropriate reporting takes place and interventions are implemented to provide the vulnerable adult with a safe living environment. When in doubt be sure to report. The administrator is notified immediately.

SUGGESTED METHOD FOR CORRECTION: The administrator, DON, or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, or designee(s) could provide training for all appropriate staff on the timelines for reporting and monitor the timelines of reports. The administrator, DON, or designee(s) could randomly audit reports of abuse that are being reported and investigated. The results of the audits could be reported to the facility's quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5339027

Dear Administrator:

The above facility was surveyed on September 17, 2018 through September 20, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

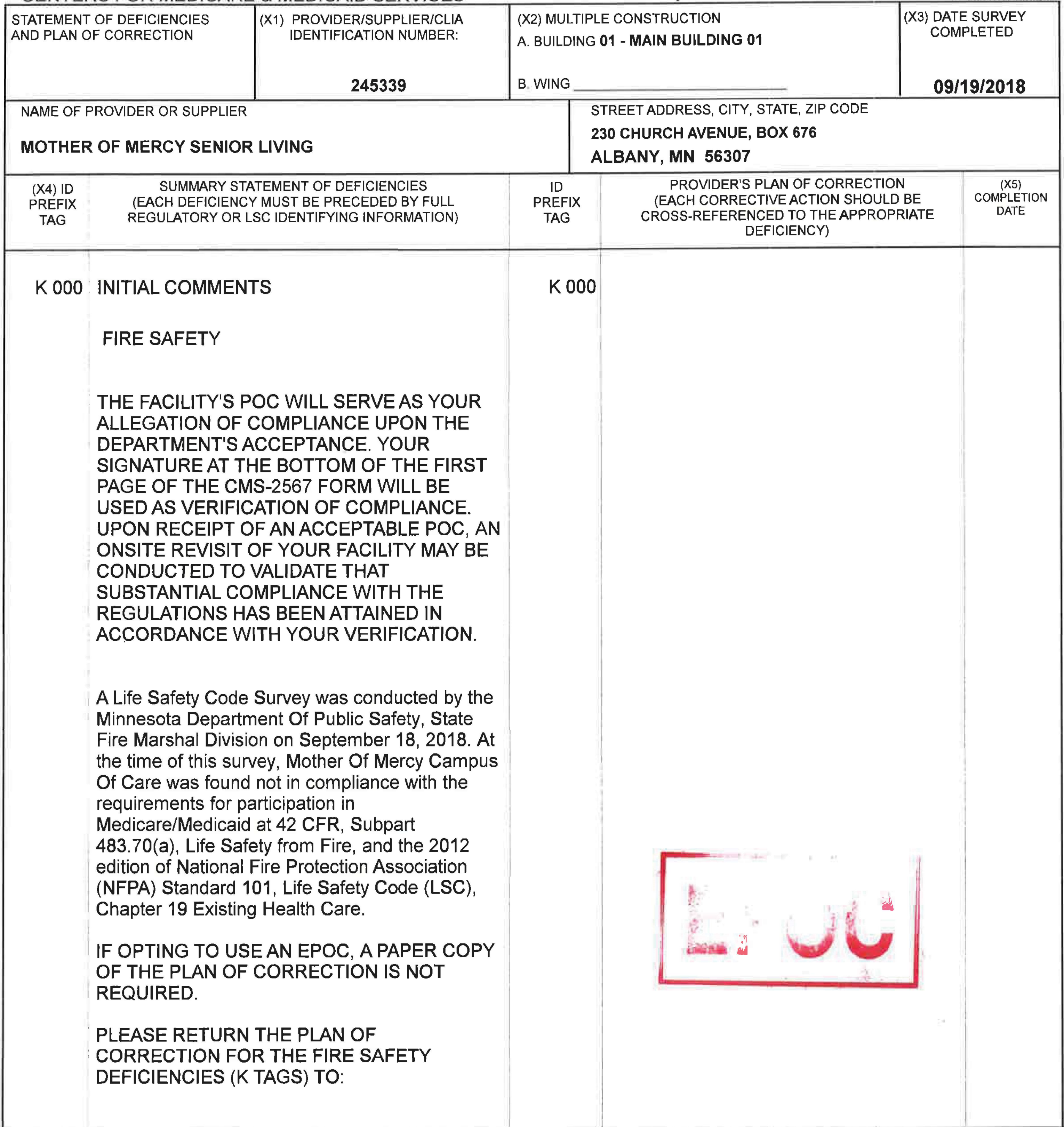
Please feel free to call me with any questions.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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

F5339026

PRINTED: 10/10/2018
FORM APPROVED
OMB NO. 0938-0391



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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/19/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division on September 18, 2018. At the time of this survey, Mother Of Mercy Campus Of Care was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 10/05/2018

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
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K 000	Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mother Of Mercy Campus Of Care is a 3 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1983 and was determined to be of Type II(222) construction. In 1999, an addition (Welcome Room) was added to the east that was determined to be of Type V(111) construction. In 2009 the 3rd floor addition was added to the facility above the existing 1983 building and was was determined to be of Type II (111) construction. The 3 buildings have a 2 hour fire separation between the 1983, 1999, and 2009 buildings and additions and the entire facility was downgraded to Type II (111) construction. The facility was surveyed as one facility. The building is fully sprinkler protected and the sprinkler system is installed in accordance with	K 000		

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K 000	Continued From page 2 NFPA 13 the Standard for the Installation of Sprinkler Systems. The facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a licensed capacity of 73 and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		10/29/18

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K 918	Continued From page 3 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all 73 patients and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: On the facility tour between 9:00 AM to 1:00 PM on 09/18/2018 record review and staff interview revealed: 1) The weekly generator log was not completed for 12/6/2017-12/13/2017 due to the generator not being functional. 2) Annual load bank test was not performed. This deficient conditions was confirmed by the Environmental Services Director.	K 918	1) Load bank test will be performed on generator per regulations. Weekly generator log will be maintained. 2) Contractor will perform generator load bank test on 10/29/2018. Load bank test will be scheduled with contractor per regulations. Weekly generator log have been kept since 12/13/2017 and will be done ongoing. 3) Ron Zierden, Director of Environmental Services or designee will be responsible for correction and monitoring of this deficiency to prevent a reoccurrence.	

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