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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: TWZ4

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00634

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/05/2022** (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 **70** (L18)

13.Total Certified Beds **70** (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 |
|---|---|---|---|---|
| | 70 | | | |
| (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 02/04/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 02/04/2022 (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
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

Electronically delivered
February 4, 2022

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 December 22, 2021 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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

Electronically delivered
February 4, 2022

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

RE: CCN: 245339
Cycle Start Date: November 18, 2021

Dear Administrator:

On December 8, 2021, we notified you a remedy was imposed. On January 14, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 22, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 23, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 23, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 22, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

February 4, 2022

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

RE: Project Number

Dear Administrator:

On January 25, 2022, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $0.00was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on January 25, 2022 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $0.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $35.96, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $35.96 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: TWZ4

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00634

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245339**
2.STATE VENDOR OR MEDICAID NO.
(L2) **222043100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/29/2021** (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 **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 70 | | | |
| (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 :
Deborah Willis, HFE - NE II 1/25/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/25/2022 (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
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

# NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered
January 25, 2022

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

Re: CCN: 245339
Cycle Start Date: November 18, 2021

Dear Administrator:

On December 29, 2021, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 18, 2021 with orders received by you electronically on December 8, 2021.

State licensing orders issued pursuant to the last survey completed on January 18, 2022, found not corrected at the time of this December 29, 2021 revisit and subject to penalty assessment are as follows:

21426 -- MN St. Statute 144A.04 Subd. 3 -- Tuberculosis Prevention And Control $0.00

The details of the violations noted at the time of this revisit completed on December 29, 2021 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $0.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Program Assurance Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TWZ4

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00634

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245339**
2.STATE VENDOR OR MEDICAID NO.
(L2) **222043100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/18/2021** (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** | |
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| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

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

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From (a) :
To (b) :

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___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 70 | | | |
| (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 :
Deb Willis, HFE - NE II 01/03/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/27/2022 (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 :

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**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
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 8, 2021

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

RE: CCN: 245339
Cycle Start Date: November 18, 2021

Dear Administrator:

On November 18, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

## REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 23, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 23, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 23, 2021.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 23, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mother Of Mercy Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 23, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

## DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 18, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

## APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245339 | A. BUILDING _____ B. WING _____ | C 11/18/2021 |

| 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 |
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| E 000 | Initial Comments<br><br>On 11/15/21, to 11/18/21,, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 041 SS=F | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(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.<br><br>§483.73(e), §485.625(e)<br>(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.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator | E 041 | | 12/1/21 |

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

Electronically Signed | 12/18/2021

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| E 041 | Continued From page 1<br>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.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [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.<br><br>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.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]<br>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 | E 041 | | |

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| E 041 | Continued From page 2<br>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.<br>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.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to test and maintain the emergency generator per NFPA 101 (2012 edition), The Life Safety Code, sections, 9.1.3 and NFPA 110 (2010 | E 041 | Tag 0041: The Emergency Generator Test log now has a line added to verify and document that the Emergency Generator is tested at 30% load or more | |

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| E 041 | Continued From page 3<br>edition), Standard for Emergency and Standby Power Systems, section 8.4.2. This deficient finding could potentially affect all the residents in the residents within the facility.<br><br>Findings include:<br><br>Review of the fire door test and inspection documentation provided by the facility on 11/17/21, at 10:07 a.m. indicated the facility could not provide documented information that verified the emergency generator had been tested monthly at 30% of the generator Kilowatt rating.<br><br>In an interview with the Environmental Services Manager on 11/17/21, at 10:08 a.m. he stated he performed the monthly testing of the emergency generator but did not document this information.<br><br>In an interview with the administrator on 11/18/21, at 12:50 p.m. he stated hewas not aware that the monthly testing of the emergency generator had not been documented, however, he expected the Environmental Services Manager to not only perform the monthly testing but document that it had been performed too. | E 041 | of the generator kilowatt rating. The Maintenance Director will be responsible for maintaining the monthly testing and documentation in the Emergency Generator Test Log. This was completed on December 1, 2021. | |
| F 000 | INITIAL COMMENTS<br><br>On 11/15/21, to 11/18/21,, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be UNSUBSTANTIATED: | F 000 | | |

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| F 000 | Continued From page 4<br>H5339029C MN58757<br>H5339038C MN60817<br>H5339037C MN61394<br>H5330932C MN63059<br>H5339036C MN64886<br>H5339035C MN67023, MN67028<br>H5339034C MN77705<br>H5339033C MN60306<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 551 SS=D | Rights Exercised by Representative<br>CFR(s): 483.10(b)(3)-(7)(i)-(iii)<br><br>§483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.<br>(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.<br>(ii) The resident retains the right to exercise those | F 551 | | 11/30/21 |

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| F 551 | Continued From page 5 | F 551 | | |

rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.

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| F 551 | Continued From page 6<br>(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.<br>(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, observation and document review, the facility failed to act for 1 of 1 resident reviewed for rights exercised by representative when the court-appointed resident representative (R40) requested resident (R54) move to the floor near R40 and R46, who are family.<br><br>Findings include:<br><br>R54's annual Minimum Data Set (MDS) dated 8/17/21, indicated R54 had severe cognitive impairment, and required staff assistance with all activities of daily living (ADLs).<br><br>R54's Physician Order Report printed 11/18/21, indicated R54 resided on the second floor, and R54's diagnoses included lack of expected normal physiological development in childhood, disorder of psychological development, developmental disorder of speech and language, macular degeneration, and epilepsy.<br><br>A Psychologist Evaluation dated 4/26/2000, indicated R54's cognitive ability (the way she thinks and organizes information) approximates the five-year-old level.<br><br>R40's guardianship documents provided by the facility, and a second identical set provided by R40, indicated R40 was appointed co-guardian of R54 on 11/21/18, along with another individual; | F 551 | F551: Pursuant to court-appointed resident representative's (R40) wishes, resident (R54) was moved to the same floor as R40 and R46, who are family, on 11/30/2021. Resident representative and guardianship rights were reviewed with Leadership team on 12/10/2021 to educate them on future related situations and for making correct decisions on this in the future. Leadership Team members shall all be responsible to ensure resident representative and guardianship rights are followed. | |

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| F 551 | Continued From page 7 | F 551 | | |

and again, with a new co-guardian appointed on 09/28/21.

On 11/15/21, at 7:27 p.m. R40 stated she had repeatedly requested, both orally and in writing, to have R54 moved to the first floor to be near R40 and R46. R40 stated the facility repeatedly told her "no". R40 stated R54's cognitive issues were present since birth, she assumed guardianship of R54 when their mother could no longer, and she has no difficulty carrying out her duties as guardian.

A progress note written by social worker (SW)-1, dated 7/12/21 at 12:06 p.m. indicated R40 asked SW-1 why R54 was not moved to the first floor where R40 and R40's spouse reside, and the administrator stated "will be following up with R40 to explain why R54 will not be moving". The progress note further indicated the Inter-Disciplinary Team (IDT) had determined "it was not in [R54's] best interest to reside on the same living unit with R40. Additionally, the progress note indicated, "R40 has been noted on several occasions to make all decisions for R54".

A Care Conference progress note written by the director of social services (DSS), dated 9/7/21 at 12:34 p.m. indicated "this is where the care conference focus shifted irreparably away from R54's care", "the rest of the care ...siblings were also advocating for R54 to move to the unit that R40 lives".

A Care Conference progress note written by registered nurse (RN)-2, dated 10/28/21, at 7:32 p.m indicated a conference was held to discuss the "best place" for R54 to reside, and "IDT has concerns about moving resident off of second

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| F 551 | Continued From page 8 | F 551 | | |

floor. Concerns include controlling and manipulate behaviors demonstrated by R40 in the past, there being no need for [R54] to be on a locked unit, how resident would react/adjust/handle transition to new environment, new staff and possible roommate". The progress note further indicated, "family is wondering if transition to 1st floor could happen so [R40, R54, and R46] could all be in closer proximity" and they "have always been a tight family unit and states that [R54] has appeared more depressed as of late". Additionally, the progress note indicated the ombudsman spoke about "how the court system appointed [R40] to be co-guardian over R54 meaning they have a choice when it comes to where [R54] lives ...", and that nursing explained, "IDT still has control/say over residents' placement in facility because resident has no need to be on 1st flood [sic] (locked dementia unit)".

On 11/16/21, at 1:25 p.m. DSS stated R40 "always liked to be in control in that family dynamic" and "has always viewed [R54] as her child". DSS stated R40 is R54's legal guardian, but she believed R40 was not cognitively capable. DSS stated R40 wanted to move R54 and "staff are very concerned about her "micro-management" of R54. DSS further stated the new co-guardian came to a meeting with R40 and a couple other siblings, with the ombudsman on the phone, to discuss moving R54. DSS stated that the co-guardian wanted to meet with R54 to ask her if she wanted to move, and the facility was waiting for the co-guardian to return from a trip to meet with R54.

On 11/16/21, at 2:25 p.m. SW-1 stated that the situation was complex because R54 had

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| F 551 | Continued From page 9 | F 551 | | |

co-guardians, and co-guardians need to agree on decisions. SW-1 stated, "That's how I interpret it, I don't know that it's an actual rule". SW-1 further stated that other residents have guardians/resident representatives, and the facility honors their decisions. SW-1 stated, "I guess it's easier to honor their choices. We have documentation where she is manipulative and controlling towards her sister" and "the clinical definition of manipulative is really just controlling, not allowing someone to make their own decisions. It's just a word that we're using". Additionally, SW-1 stated the court declared R40 competent to be R54's co-guardian. SW-1 stated R54 required a guardian because of her developmental disability with R40 had been her guardian since 1990. SW-1 further stated she, the nurse manager, and the ombudsman asked R54 if she wanted to move, "but it didn't go well because there were too many people in the room".

On 11/17/21, at 1:28 p.m. administrator stated, "If a resident had an assigned guardian, we would basically honor their wishes, and if the request was reasonable and the guardian was competent to ask for those things". The administrator stated, R40 had been R54's "caregiver for all these years, so does she just keep making these choices?" The administrator further stated, "the guardian's role was to communicate needs and wants, not to make clinical decisions".

On 11/17/21, at 4:12 p.m. family member/co-guardian (FM)-1, stated she wanted R40 to be moved to first floor and she could tell during the last care conference that the facility would not move R54 to a double-room, even though it was what R40 and FM-1 wanted. FM-1

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| **MOTHER OF MERCY SENIOR LIVING** | **230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307** |

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| F 551 | Continued From page 10<br>further stated, "They say they asked [R54] and she said no. I just don't trust that they are asking her in a way she understands. R40 and her husband have been [R54's] guardians for many, many years. She is like their child. I trust them. They have never made anything but wise and loving decisions for [R54]. I defer to R40 completely. When COVID hit, it was very hard on [R54] not to be able to see [R40 and her husband]".<br><br>On 11/17/21, at 5:42 p.m. director of nursing (DON) stated she thought the social workers and the administrator were handling the concern, and by the time she became the DON, "everyone had their heels dug in". DON asked, further stated R40 is a very good advocate for R54, has a hard time taking a step back to let staff do their job, but she would not have done anything differently if it were her family member. Additionally, DON stated a resident's guardian had the right to have input regarding the resident's care.<br><br>Although requested, no policies regarding guardianship, social services, and resident rights were provided. | F 551 | | |
| F 564 SS=E | Inform Visitation Rghts/Equal Visitation Prvl<br>CFR(s): 483.10(f)(4)(vi)(A)-(D)<br><br>§483.10(f)(4)(vi) A facility must meet the following requirements:<br>(A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the | F 564 | | 12/6/21 |

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| F 564 | Continued From page 11<br>restrictions apply, when he or she is informed of his or her other rights under this section.<br>(B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.<br>(C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.<br>(D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident group interview, and record review, it was determined the facility failed to inform residents when visitation restrictions were implemented or lifted in conjunction with the COVID-19 pandemic, as reported by six of the seven residents (R2, R10, R33, R40, R46, and R48) who attended the resident group, and had the potential to cause distress and feelings of isolation when residents were unsure of these restrictions.<br><br>Findings include:<br><br>During the resident group interview on 11/17/21, at 10:29 a.m., six of the seven residents (R2, R10, R33, R40, R46, and R48) stated that the facility had to implement visitation restrictions any time a staff member or resident tested positive for COVID-19, then at a later date would relax those restrictions. The residents stated that the facility | F 564 | F 564: We identified 42 residents in the facility who are currently wheelchair-bound. Visitation postings have been moved to be posted near elevator on each floor, at eye level for wheelchair-bound residents' ease of reading. Updated visitation policies will be provided in writing to all residents as changes occur. The Administrator, Director of Social Services, and Director of Nursing will ensure compliance of visitation postings. This was completed on 12/06/2021. | |

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| F 564 | Continued From page 12<br>notified their families of these changes, and notified residents when restrictions were implemented, but did not notify residents when the restrictions were lifted. The residents stated that they had been told this information was posted somewhere, but they were not sure where and did not feel it was accessible to them. Five of the six residents in the group (all but R40) were wheelchair dependent.<br><br>An interview with the Infection Preventionist (IP) on 11/18/21, revealed the facility posted a detailed list of visitation requirements near the elevator on each floor, which she kept updated regularly. The IP took the surveyor to look at the postings, which were at eye level for an ambulatory person. The IP stated, "Well, I guess that's not really accessible to them if they're in a wheelchair." The IP stated the facility did not have a policy regarding informing residents of visitation restrictions related to COVID or posting those restrictions for residents.<br><br>An interview with the administrator on 11/17/21 at 1:54 p.m. revealed he would expect postings of information pertinent to the residents to be accessible and in a size and format they could read. | F 564 | | |
| F 575 SS=E | Required Postings<br>CFR(s): 483.10(g)(5)(i)(ii)<br><br>§483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:<br>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult | F 575 | | 12/2/21 |

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| F 575 | Continued From page 13<br>protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and<br>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident group interview, and record review, it was determined the facility failed to post accessible contact information for the State Survey Agency (SSA) or Ombudsman, as reported by six of seven residents (R2, R10, R33, R40, R46, and R48) who attended the resident group.<br><br>Findings include:<br><br>During the resident group interview on 11/17/21, at 10:29 a.m., five of the seven residents (R2, R10, R33, R46, and R48) stated they did not know about the Ombudsman program or that they could file a complaint with the SSA. Six of the seven residents (R 2, R10, R33, R40, R46, R40 and R48) stated that they did not know where the contact information was posted for these programs.<br><br>An interview and observation with the Director of | F 575 | F575: The Facility purchased new Medicare/Medicaid large-print posters and State residents Bill of Rights large-print posters on 12/02/2021. These posters have since been placed in a conspicuous area on each of our three care units. Information regarding the State Survey Agency(SSA) and Ombudsman will also be reviewed with residents at the next Resident Council meeting in January, 2022. The Administrator, Social Services Director, and Director of Nursing will be responsible for ensuring these information posters remain visible for residents. | |

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| F 575 | Continued From page 14<br>Social Services (DSS) on 11/17/21, at 11:32 a.m. revealed the contact information was posted on each floor across from the elevator. The observed information was in a very small font, at the bottom of a large poster. When asked if a resident would be able to read the contact information, the DSS stated, " I think they could if they wanted to." When asked if she could read the information, the DSS stated, "no."<br><br>An interview with the administrator on 11/17/21, at 1:54 p.m. revealed that he thought the postings met the regulatory requirement since font size was not specified. The administrator stated that the facility did not have a policy on posting contact information for the SSA or the Ombudsman program. | F 575 | | |
| F 577 SS=B | Right to Survey Results/Advocate Agency Info<br>CFR(s): 483.10(g)(10)(11)<br><br>§483.10(g)(10) The resident has the right to-<br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>§483.10(g)(11) The facility must--<br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with | F 577 | | 12/10/21 |

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| F 577 | Continued From page 15<br>respect to the facility, available for any individual to review upon request; and<br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident group interview, and record review, it was determined the facility failed to make the results of the most recent survey available to residents and the public, as reported by six of the seven residents (R2, R10, R33, R40, R46, and R48) who attended the resident group.<br><br>Findings include:<br><br>During the resident group interview on 11/17/21, at 10:29 a.m., six of the seven residents (R2, R10, R33, R40, R46, and R48) stated they did not know where the state survey results were kept in the facility.<br><br>Interview and observation with the Director of Social Services (DSS) on 11/17/21, at 11:32 a.m. revealed the state survey results were available in the second-floor lobby, which was separated from resident living and care areas by a long hallway. The state survey results for the first and third floors were kept in an upper cabinet behind each nurses' station, respectively, and the most recent survey results in each book was three years old.<br><br>In an interview on 11/17/21, at 1:54 p.m., the administrator stated, "Yes, I've been told they're out of date and out of reach." The administrator also stated the facility did not have a policy | F 577 | F577: This had the potential to affect all 52 residents currently in the facility. Binders containing past state survey results were updated and placed in common resident areas where they are easily accessible to all residents and visitors, without residents/visitors having to ask for them. Facility Administrator updated binders and placed them in accessible locations on 11/18/2021. Director of Nursing to conduct audits to ensure binders remain up to date and in these easily accessible locations. Audits to be completed weekly for 4 weeks, then monthly for 3 months, then quarterly for 2 quarters. | |

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| F 577 | Continued From page 16<br>regarding the posting of survey results. | F 577 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg<br>CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS) assessment within fourteen (14) days after the facility determined, or should have determined, that there had been a significant change in the resident's physical or mental condition for 1 of 24 residents (R30).<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument RAI 3.0 User's Manual, Version 1.17.1 dated October 2019, Chapter 3, page 2-23, indicated a significant change in status assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program and remains a resident at the nursing home. The | F 637 | F637: Significant change in status assessment for R30 was completed on 11/17/2021. This had the potential to affect all 52 residents in facility. All other residents' MDS assessments checked for timeliness of completion on 12/15/2021 and found to be compliant. Director of Nursing to conduct audits to check for compliance of timely completion of MDS assessments. These audits to be completed on all MDS assessments daily for 2 weeks and if no concerns found audits will decrease to MDS assessments due 3 days per week (Monday, Wednesday, Friday) for 2 weeks. If no concerns found upon 3 day per week checks, compliance audits will decrease to an as needed basis only. | 12/22/21 |

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| F 637 | Continued From page 17 | F 637 | | |

assessment reference date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on a resident. This is to ensure a coordinated plan of care between the hospice and nursing home are in place.

R30's Face Sheet located in the Electronic Medical Record (EMR) located under the Face Sheet tab indicated R30 had diagnoses of unspecified dementia without behavioral disturbance and heart failure.

Review of R30's quarterly MDS located in the EMR under the MDS 3.0 Assessments tab with an ARD of 9/29/21, indicated the quarterly MDS was the last comprehensive assessment completed.

R30's Service Agreement - Hospice, dated 11/02/21, provided by the facility, indicated R30 participated in the development of the agreement to receive hospice services and development of the care plan.

On 11/18/21, at 9:24 a.m. the drector of nursing (DON) stated the nurse managers were responsible for completing the MDS assessments and a SCSA should be completed within 14 days of the hospice program election. The DON confirmed a SCSA should have been completed for R30 and it should have been marked on her calendar to submit by 11/15/21, but she missed the date. The DON stated the facility didn't have a policy for the completion of MDS assessments; however, the RAI 3.0 User's Manual was used as

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| F 637 | Continued From page 18<br>a reference when completing MDS assessments. | F 637 | | |
| F 745 SS=G | Provision of Medically Related Social Service CFR(s): 483.40(d)<br><br>§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide medically related social services to 1 of 1 residents (R40). The failed practice caused R40 psychological harm, in that R40 experienced ongoing anxiety and frustration when she was not allowed to fulfill her duties as R54's legal guardian.<br><br>Findings include:<br><br>R40's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/20/21, indicated a Brief Interview of Mental Status (BIMS) score of 15, which indicated she was cognitively intact, and a Personal Health Questionnaire, 9th version (PHQ-9) score of 0, indicating no depression present.<br><br>R40's quarterly MDS assessment with an ARD of 7/16/21, indicated a BIMS score of 15, and a PHQ-9 score of 4, which indicated minimal depression present.<br><br>R40's post-hospitalization re-admission MDS with an ARD of 9/27/21, indicated a BIMS of 15 and a "PHQ-9" score of 0. A significant change of condition MDS with an ARD of 10/20/21, also | F 745 | F745: The identified deficient practice had the potential to affect all 52 residents in the facility. Resident R40 was already being seen by a provider from Associated Clinic of Psychology (ACP) and has continued to be seen by this provider. Most recent in person meetings between ACP provider and R40 took place on 11/03/2021, 11/17/2021, and 12/08/2021. Documentation from the ACP provider note from 12/08/2021 visit states, “Denies any concerns within the facility this date and was excited to share that her sister now is on her floor and she shares ‘it’s just been wonderful; it’s the way it should be’ . . . Denies any sleep, mood or anxiety related concerns on this date.” R40 continues to be on caseload for ACP provider. Going forward, Department of Social Services will reach out to Associated Clinic of Psychology (ACP) with any significant decline noted in resident’s mood/behavior, as evidenced by increased depression noted on PHQ-9 assessment. Any recommendations from ACP will be followed to prevent harm to residents. Was completed on 12/17/2021. Director of Nursing will audit to ensure this | 12/17/21 |

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| F 745 | Continued From page 19<br>indicated a BIMS of 15 and a PHQ-9 score of four. Specifically, on the 10/20/21, PHQ-9, R40 reported feeling down, depressed, and hopeless at least once; and that she had failed or let her family down at least half of the time.<br><br>R40's guardianship documents provided by the facility, and a second identical set provided by R40, indicated R40 was appointed co-guardian of R54 on 11/21/18, along with another individual; and again, with a new co-guardian appointed on 09/28/21.<br><br>Review of the floor plan and census list provided by the facility on 11/15/21, indicated R40 and R46 (R40's husband) lived on the first floor of the facility and R54 lived on the second floor.<br><br>In an interview on 11/15/21, at 2:51 p.m. R40 became tearful when asked about her treatment in the facility. R40 reported that she had a sister, R54, who had suffered an anoxic brain injury at birth and functioned at a cognitive level comparable to a 5-year-old, who also resided in the facility. R40 stated that she and her husband (R46) had been R54's co-guardians for over 50 years. R40 stated that when R46 was diagnosed with dementia, she obtained a new co-guardian. R40 stated that beginning in January 2021, following a hospital stay in which R40 experienced some delirium, the facility had stopped allowing her to make decisions on R54's behalf or participate in R54's plan of care. R40 stated that the facility cited various reasons as to why they were implementing those restrictions, including the delirium she experienced while acutely ill, an assertion that R40 was interfering in R54's care, and R40's visual deficits. R40 reported that the facility did not inform her that | F 745 | practice is being followed. Audits will be conducted by comparing an individual resident's current PHQ-9 score with their last PHQ-9 score. Audits will be done on 5 residents per month for 2 months, then on 3 residents per month for 2 months, until 100% compliance is met. | |

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they were utilizing the co-guardian to make decisions, and the co-guardian did not open financial mail which placed both R40 and R54 at risk of not having a funding source for the nursing home. R40 stated that, on her own, she hired an attorney and went back to court to establish a new co-guardian for R54. The new co-guardian was a third sister, family member (FM)1.

In continued interview with R40 on 11/15/21, at 2:51 p.m. R40 stated her most pressing concern was moving R54 to the same floor as she and R46, as when the facility implemented visitation restrictions necessary for COVID-19 outbreaks, they limited residents to the floor where they each lived. R40 stated she understood why the facility had to implement these restrictions, but it meant there were extended periods of time when R54 did not have any family contact. R40 stated she had started making these requests many months ago, because in 2020 the family ended up spending both Thanksgiving and Christmas apart. R40 stated that she was becoming increasingly distressed and frustrated as the holidays approached again, because if there was another COVID-19 outbreak they might be separated for yet another holiday. R40 stated that also important, but to a lesser degree, was that she had made specific care plan requests for approaches and effective communication with R54. R40 stated that the facility refused to implement these approaches. R40 stated that she had spoken with the facility's administrator, director of nursing (DON) and social workers regarding these concerns, but they told her what happened to R54 was "not your concern." R40s stated that she had involved the Ombudsman as an advocate in the situation, and the Ombudsman agreed with all R40's concerns; but the facility

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refused to act upon the Ombudsman's recommendations. R40 stated that the Ombudsman had offered to help her find alternative placement for the family, but none of them wanted to do that. R40 stated that they had chosen this facility because it was affiliated with their faith and had daily spiritual support.

In an interview on 11/16/21 at 12:13 p.m., R40 stated FM1, who was R54's co-guardian, was in another state with one of their brothers, who was on hospice care and nearing the end of his life. R40 stated that the facility was waiting for FM1 to return before moving R54 to the same floor as R40 and R46. R40 stated that the facility felt this was because FM1 did not agree with the room move, but the facility's perceptions were incorrect. R40 stated, "That's a blatant lie. [FM1] wants [R54] moved to be with [R46] and me. I have fought this for so many months. It's all I think about."

In an interview on 11/16/21, at 1:24 p.m. the director of social services (DSS) stated she was aware of R40's status as R54's legal guardian, which the DSS stated meant R40 had the authority to make health care and placement decisions on R54's behalf. The DSS stated that "a year or so ago" R40 was hospitalized, and it was determined she had a cognitive deficit at that time. The DSS stated that R40 agreed to have a co-guardian for R54 at that time, then became upset when the co-guardian did not make the care decisions R40 felt were appropriate, such as moving R54 to the first floor, and did not follow through with information requests to secure Medicaid. The DSS stated that the facility felt R40 was not making decisions based on R54's best interests, so the facility had refused to honor

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R40's requests they felt violated R54's rights. The DSS stated that R40's visual deficit made it difficult for her to be independent and combined with her cognitive deficits impaired her ability to serve as R54's guardian. The DSS stated that after R40's hospitalization in January 2021, her cognition "seems to have cleared" and could not cite evidence of a current cognitive deficit. The DSS was unable to state how R40's visual deficit impacted her ability to fulfill her duties as R54's legal guardian. The DSS stated that FM1, who was R54's co-guardian, agreed with the facility's assessment that R40 was not making decisions in R54's best interest and wanted to talk to R54 before anything was changed. The DSS stated that after making this known to facility staff, FM1 "went on vacation or something, and left without doing anything about it. There's nothing we can do until she comes back, and she didn't tell us when that was going to be." The DSS stated that the Ombudsman was involved and supported the facility's decision to delay moving R54 until FM1 returned and spoke to R54 independently.

In an interview on 11/16/21, at 2:36 p.m., social worker (SW)-1 stated she was familiar with R40 and knew that R40 was R54's guardian. SW1 stated that R40 was "manipulative and controlling" towards R54. When asked for details of this assessment, SW1 stated that R40 had seen staff serving R54 both chocolate milk and hot chocolate prior to a meal and told staff to offer R54 one or the other until she had been presented with her meal, though staff knew R54 liked both items. SW1 stated that based on these types of interactions, the facility had determined R40 was making "inappropriate" decisions for R54. SW1 also stated that R40 had cognitive deficits which interfered with her ability to serve

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as R54's guardian. SW1 stated that the facility had not notified either R40's physician of their concern with her cognition or notified the court that they were concerned with R40's ability to carry out her court-appointed duties as guardian.

In an interivew on 11/16/21, at 5:54 p.m., the ombudsman stated R40 had contacted her to ask her to advocate for R54 and R40. The Ombudsman stated she understood the facility was concerned with the decisions R40 was making but encouraged the facility to defer to R40 as R54's guardian. The Ombudsman stated that R54's current co-guardian (FM1) was in support of the decisions R40 was making and recommended to the facility that they follow those wishes. The Ombudsman stated she was not confident that the facility planned to listen to R40 and FM1. The Ombudsman stated that she had not noticed any obvious cognitive deficits for R40 during their interactions.

When asked in an interview on 11/16/21, at 6:26 p.m. R40 stated that there was no disagreement between her and FM1 as far as the request for R54 to move nearer to her or the input she had for R54's care. R40 stated, "Please call [FM1] and ask her. I don't know why they [the facility] has been so gruesome in their treatment of me." R54 expressed concern that facility leadership, specifically the DON and administrator, would retaliate against her for reporting to the survey team by further restricting her access to R54.

In an interview with registered nurse (RN) nurse manager 2 on 11/17/21, at 8:20 a.m., she stated that she was the unit manager for the first floor, where R40 and R46 resided. RN Nurse Manager 2 stated that she was aware that R40 was R54's

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guardian and the facility's concern with her making decisions on R54's behalf. RN Nurse Manager 2 described R40 as "forgetting things that happened when she was sick, and a couple of other things like that" but had not been concerned with R40's cognition to the point that she felt they needed to notify the physician for further work-up. RN Nurse Manager 2 stated, "I said months ago that they should just move her [R54] down here, but for some reason they just don't want to."

In an interview on 11/17/21, at 12:21 p.m., R40's physician (MD) stated R40 had not been diagnosed with a cognitive deficit. The MD stated that a year ago R40 had experienced a delirium during a hospitalization but had since cleared and returned to baseline. The MD stated that R40 did not have a cognitive deficit, or any other deficits, which would preclude her from fulfilling her duties as guardian. The MD stated he knew R40 had been R54's guardian for "decades" and there had never been any concerns brought to his attention. The MD stated that he was aware of the conflict R40 had had with the facility regarding this issue. The MD stated, "[R40] has depression and anxiety at baseline and this hasn't helped, that's for sure. In my opinion you pick your battles carefully and why they picked this one is beyond me."

In an interview on 11/17/21, at 12:55 p.m. the DSS and SW1 both stated the facility did not have a policy on the provision of medically-related social services.

In an interview on 11/17/21, at 1:28 p.m. the administrator stated he was aware R40 was the legal guardian for R54. When asked about a

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guardian's role, the administrator stated, "If a resident has an assigned guardian, we would have to basically honor their wishes, if the request was reasonable and the guardian was competent to ask for those things." The administrator stated that he would have to defer to "clinical" to determine if requests were reasonable, and to "legal" to determine if a guardian was competent to make requests. The administrator described R40 as being "very domineering," citing again the example with hot chocolate and chocolate milk SW1 had previously mentioned. The administrator verified the facility lacked a policy on the provision of medically related social services.

In an interview on 11/17/21, at 4:12 p.m. FM1 confirmed that R40 had been R54's guardian for at least 40 years. FM1 stated, "I defer to [R40] completely. I could tell in the last meeting we had that they were not going to move [R54] even though both [R40] and I thought it was fine. Even though they said they talked to [R54] I just don't trust that they are asking her [R54, regarding the room move] in a way she understands. I have known [R40] and [R46] to make wise and loving decisions for [R54]. I defer completely." FM1 described the facility's failure to allow R40 to fulfill her duties as guardian as, "Hard on her. Very hard. I think she's started to feel some of the staff are dismissive and rude. It's caused her a lot of anxiety, a lot of worry."

An interview with R40 on11/17/21 at 4:46 PM revealed, "You can't imagine what I have been through over the past year. The facility has tried to convince so many people I'm incapacitated. They have abused me with this, I can't deny that. There's no one I could talk to." R40 stated that

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| F 745 | Continued From page 26<br>she had been told by the social workers, nurses, and Administrator that it was the DON who would ultimately make the decision about whether to allow her to fulfill her duties as R54's legal guardian.<br><br>In an interview on 11/17/21, at 5:42 p.m. the DON stated she had stepped into her current role a month and a half ago but was familiar with the situation due to her previous position at the facility. The DON stated that she presumed the social workers and administrator were overseeing their concerns and she had concentrated on clinical issues rather than psychosocial ones. The DON stated that she was "horrified" to learn that R40 was feeling ignored and abused by the situation. The DON stated, "I've known [R40] for a long time. As far as I'm concerned, we can move [R54] any time. I've thought that since the beginning, but by the time I became the DON everyone had their heels dug in against the move, so I haven't been able to make it happen." | F 745 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that--- | F 758 | | 12/22/21 |

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| F 758 | Continued From page 27<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 5 residents (R17, R32) with dementia received antipsychotics only for specific target symptoms, only after other | F 758 | F758: Through review of all residents receiving antipsychotic medications, it was found that 2 additional residents were receiving antipsychotic medications for | |

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| F 758 | Continued From page 28<br>non-pharmacological interventions had been attempted, gradual dosage reductions were attempted, and the use of antipsychotic medications were monitored for effectiveness.<br><br>Findings include:<br><br>R17's Face Sheet, located under the Face Sheet tab of his electronic medical record (EMR) indicated R17 had diagnoses which included Parkinson's disease, dementia with behavioral disturbances, history of transient ischemic attacks (TIAs), and cerebral infarction without residual effects.<br><br>R17's Physician's Orders, located under the "Orders" tab of the EMR, indicated a new order dated 5/27/21, for the anti-psychotic medication Seroquel 50 milligrams (mg) three times daily for a diagnosis of Dementia in other diseases classified elsewhere with behavioral disturbance - w/ [with] Parkinson's.<br><br>R17's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/07/21, indicated a Brief Interview of Mental Status (BIMS) score of three out of 15, which indicated severely impaired cognition; a Personal Health Questionnaire version 9 (PHQ-9) score of zero, which indicated no depression; no hallucinations or delusions; non-physical or non-verbal behavioral symptoms directed at others most days which were not assessed to interfere in the care of this resident or others; no rejection of care; and no wandering behaviors noted.<br><br>R17's progress notes, located under the Progress Notes tab of his EMR, revealed no documentation | F 758 | dementia diagnoses with no specific target behaviors identified. Specific target behaviors identified for R17 and R32, as well as these 2 additional residents, at IDT meeting on 12/22/2021. Orders entered into eTAR identifying each of these residents' target behaviors and instructing nursing staff to chart in a progress note every shift if any of these behaviors are present. Director of Nursing to audit for continued compliance of identified target behaviors and related charting with these and any additional residents being prescribed antipsychotics with a diagnosis of dementia. Audits of specific target behaviors and associated charting to take place for all affected residents on all shifts once weekly for 4 weeks, then once monthly for 2 months. IDT will audit for continued compliance and appropriateness of ongoing antipsychotic drug regimens for all residents on a quarterly basis. | |

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of R17 having hallucinations or delusions.

R17's Behavior Occurrence forms, provided by the facility, indicated the resident was monitored for behaviors of refusal of care, yelling/verbal aggression, physical aggression, and self-transfers (actual or attempted).

In an interivew on 11/18/21, at 11:25 a.m. Registered Nurse (RN) Nurse Manager 1 stated R17 had not been receiving Seroquel when admitted on 3/09/21. RN Nurse Manager 1 stated she was not sure what specific target behavior prompted the addition of an antipsychotic medication, but "I would probably say physical aggression." RN Nurse Manager 1 stated that R17 would grab onto the wrists of staff caring for him and refuse to let go to the point of almost injuring a staff member on one occasion. RN Nurse Manager 1 stated she did not know if the refusal to let go was anger or an inability to let go because of his Parkinson's disease. RN Nurse Manager 1 did not know what non-pharmaclogical interventions had been used prior to the start of Seroquel. RN Nurse Manager 1 stated that R17 did not appear to have hallucinations or delusions. RN Nurse Manager 1 stated that the facility either documented behaviors on the Behavior Occurrence forms, or in a progress note, but either way the behaviors documented were not specifically related to the medication ordered.

R32's Face Sheet, located under the Face Sheet tab of her EMR indicated R32 had diagnoses which included vascular dementia without behavioral disturbance and restless and agitation.

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R32's physician's orders, located under the Orders tab of her EMR revealed an order for Seroquel 50 mg three times daily beginning 10/06/20.

R32's annual "MDS" with an ARD of 10/4/21, revealed a BIMS of four out of 15, indicating severely impaired cognition; a PHQ-9 score of 0, indicating no depression; no hallucinations or delusions; and no other behavioral symptoms.

R32's Behavioral Occurrence forms, revealed target behaviors of "Refusal of Care, Yelling/Verbal Aggression," Physical Aggression, Self-transfers (actual or attempted), and Rubbing Arm."

R32's Pharmacist Recommendation to Providers, dated 10/8/21, recommended a small dose reduction in the resident's Seroquel dose as her behaviors had been stable for over a year and the facility had never tried a lower dose. The MD documented in response to this request that a previous lower dose was tried and did not go well.

In an interview on 11/18/21, at 1:52 p.m. the director of nursing (DON) stated R32 was on Seroquel at the time of admission because she had been resistive to cares in her previous assisted living setting and had rubbed her arm to the point that she had opened a sore on the arm. The DON stated R32 was still occasionally resistive with cares, but had not been noted to rub on her arm. The DON stated the facility had never attempted a gradual dose reduction for R32. The DON stated she had assumed her role at the end of September and had not yet had a chance to rework the facility's psychotropic medication practices. The DON stated it would be

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her expectation that psychotropic medications were used only for a specific target behavior, with monitoring of that specific behavior, and gradual dosage reductions attempted. The DON stated, "I know we have problems in this area. We can fix it."

In an interview on 11/18/21, at 7:14 p.m. the Medical Director stated he would expect the facility to use antipsychotic medication for residents with dementia as a "last resort" and that non-pharmacological interventions should be attempted first. The Medical Director stated he would expect the facility to evaluate resident behaviors before starting or continuing an antipsychotic for use with dementia to determine if the behaviors placed the resident or others at risk. The Medical Director stated if the facility was using an anti-psychotic medication for a resident with dementia, his expectation would be that a specific target behavior would be tracked to measure the effectiveness of the medication.

The facility policy titled Psychotropic Medication Policy and Procedure, dated 11/2021, indicated " ...Primary Care Physician...orders for psychotropic medication only for the treatment of specific medical and/or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non-pharmacologic approaches. The policy also indicated to attempt a gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications after no more than three months unless clinically contraindicated. Gradual dose reduction must be attempted for two separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter

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| **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 |
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| F 758 | Continued From page 32<br>or as the resident's clinical condition warrants. The policy further directs the facility to document the rationale and diagnosis for use and identifies target symptoms, to monitor for the presence of target behaviors on a daily basis charting by exception (i.e., charting only when the behaviors are present) and to review the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and or the presence of any adverse effects of the medication use. | F 758 | | |
| F 761 SS=F | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the | F 761 | | 12/22/21 |

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| F 761 | Continued From page 33<br>quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure controlled medications (drugs that can cause physical and mental dependence and have restrictions on how they can be filled and refilled) were stored securely on 3 of 3 medications carts. Specifically, the scheduled III, IV, and V medications were not stored in the locked drawer on the cart. Additionally, the facility failed to ensure controlled medications for 3 of 3 residents (R22, R48 and R45) were stored securely in 2 of 3 medication storage rooms (on the first and second floors) in that the locked box for controlled medications in the refrigerator was not permanently affixed to the refrigerator. This had the potential to affect all 56 residents who resided in the facility.<br><br>Findings include:<br><br>During an observation on 11/16/21, at 3:02 p.m. licensed practical nurse (LPN)-3 showed the medication cart located on the third floor contained the following schedule IV and V medications in drawer above the locked drawer:<br>1. 18 tablets of lorazepam (schedule IV medication) 0.5 milligrams (mg) for R22;<br>2. 22 tablets of tramadol (schedule IV medication) 50 mg for R48; and<br>3. 24 tablets of Vimpat (schedule V medication) 50 mg and 50 tablets of Vimpat (schedule V medication) 100 mg for R45.<br><br>In an interview on 11/16/21, at 3:05 p.m. LPN3 stated the schedule II medications were stored in the locked drawer in the medication cart, but the | F 761 | F761: All scheduled II-V medications were placed in locked drawer in locked medication carts on 11/17/2021. At this time all nursing staff were educated on the requirement for all schedule II-V medications to be double-locked at all times. Additionally, permanently affixed lock boxes were ordered on 12/21/2021 for each medication fridge for the storage of controlled medications. Anticipate lock boxes to be put in use by 12/29/2021 or sooner, as delivery of supply allows. Prior to receiving lock boxes, all refrigerated controlled medications have been moved to separate refrigerators; one in the 1st floor medication room and one in the 3rd floor medication room. Director of Nursing to complete audits to ensure compliance with storage of controlled medications on all shifts three days per week for 2 weeks, then on all shifts one day per week for 2 weeks. Consultant pharmacists will continue these audits to ensure compliance on a quarterly basis. | |

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| F 761 | Continued From page 34 | F 761 | | |

schedule III, IV and V medications were stored in a pull-out drawer located above the locked compartment where the schedule II medications were stored. LPN3 stated, to prevent drug diversion, only the nurses that were assigned the medication carts had keys to the cart and medication room.

In an interview on 11/17/21, at 10:24 a.m. the director of nursing (DON) stated she had discussed the storage of scheduled medications with the Pharmacy Consultant when the State Operations Manual (SOM) Appendix PP Guidance to Surveyors for Long Term Care Facilities was revised in 2017. The DON stated scheduled medications had to be stored under a two locked system. The DON stated the medication cart had a lock on it and the drawer in the medication cart had a lock on it which the schedule II medications were stored and only the nurses that were assigned to the medication carts had keys to the locks. The DON further stated she did not know why the schedule III, IV and V medications were not stored in the same locked drawer as the schedule II medications. The DON indicated the facility had cameras in the hallways on all floors that could be viewed to identify drug diversion.

In an interview on 11/18/21, at 6:55 p.m. registered nurse (RN) Manager1 stated she was not aware that all scheduled medications had to be stored under a double locked system. RN Manager1 stated the schedule III, IV and V medications were not stored in a locked drawer on the cart, but the medication cart was locked. RN Manager1 stated only the nurses assigned to the carts had keys to the cart and the nurses counted the scheduled medications at shift

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change. RN Manager1 further stated she reviewed the medication administration records (MAR) of the residents daily and the nurses were required to report any missing scheduled medications at shift change which had not happened while she was the manager.

During an interview on 11/19/21, at 2:30 p.m., the Pharmacy Consultant stated the scheduled medication storage regulation stated only schedule II medications had to be double locked; not the schedule III, IV, and V medications. The Pharmacy Consultant stated the facility was following the regulation because they were storing schedule II drugs in a locked drawer that was permanently affixed to the medication cart.

During observation and interview 11/17/21, at 3:56 p.m. with licensed practical nurse (LPN)-7, the second-floor locked medication cart and locked medication room were reviewed. The medication cart had a separately locked, permanently affixed compartment which contained medications classified as Schedule II controlled drugs. The Schedule III, IV, and V controlled medications were observed in a drawer that did not have a separate lock. LPN-7 stated the controlled medications were stored per facility policy with only the Schedule II controlled medications separately locked "because they're stronger". A locked medication refrigerator was in the medication room. Located on a shelf of the refrigerator were four prescription labeled boxes of lorazepam concentrate (a medication used to manage anxiety). LPN-7 stated the medication refrigerator did not contain a separately locked, permanently affixed compartment.

During observation and interview 11/18/21, at

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10:19 a.m. with registered nurse (RN)-1, the first-floor locked medication cart and locked medication room were reviewed. The medication cart had a separately locked, permanently affixed compartment which contained all classifications of controlled medications. RN-1 stated the Schedule III, IV, and V controlled medications were kept in a drawer that did not have a separate lock, but she "got an email to move the Schedule III, IV, and V's to the locked drawer". The locked medication room contained a locked medication refrigerator. Located on a shelf in the refrigerator were six prescription labeled boxes of lorazepam concentrate. RN-1 confirmed the medication refrigerator did not contain a separately locked, permanently affixed compartment.

The facility's Controlled Drug Policy and Procedure revised 11/17/21, indicated "a separate locked compartment for Schedule II drugs is provided within medication carts and in the med room fridges. The compartments have a special lock and key and must be kept locked at all times". However, the policy failed to address the storage of Schedule III, IV, and V controlled medications.

The facility's Medication Orders policy dated 8/18, indicated "IB2: Controlled Substance Prescriptions. L. Controlled substance medications are stored at the facility under double lock on the medication cart separate from all other medications and counted at each change of custody. The access key to controlled medications is not the same key that allows access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. Back-up keys to all

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| F 761 | Continued From page 37<br>medication carts may be obtained from the provider pharmacy. Controlled medications kept in the refrigerator must be double locked with lock on refrigerator and lock on the med [medication] room door." | F 761 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; | F 880 | | 12/22/21 |

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| F 880 | Continued From page 38<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure staff conducted hand hygiene (washed hands with soap and water or used alcohol-based hand sanitizer) | F 880 | F880 - DIRECTED PLAN OF CORRECTION (DPOC)<br>The deficient practices of staff related to adequate hand hygiene, appropriate | |

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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307 |

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| F 880 | Continued From page 39 | F 880 | | |

during the meal service for 2 out of 2 residents (R210 and R42) reviewed during dining. Additionally, the facility failed to ensure staff properly donned personal protective equipment (PPE) and wore proper eye protection while the facility had a high community transmission rate which had the potential to affect all 55 facility residents.

Findings include:

1. During medication administration observation on 11/16/21, at 7:16 p.m., licensed practical nurse (LPN)-5 was wearing the face mask below her nose while walking in hallway to the medication cart on the second floor. Continued observation at the second-floor nurses' station at this time revealed a sign posted on the cabinet that stated, "Effective immediately all staff and visitors are required to wear surgical style face masks and eye protection inside [facility] (regardless of vaccination status) 7/19/21, SS, RN."

During an interview with LPN5 on 11/16/21 at 7:30 p.m., LPN5 confirmed that she was wearing the face mask below her nose. LPN5 stated the mask slipped down on her nose due to the safety glasses pushing on the face mask. LPN5 stated she had been trained to wear the mask over her nose and below her chin. LPN5 stated the importance of wearing the mask over her nose was to not spread germs by droplets to the residents and other staff.

During an interview on 11/17/21, at 11:54 a.m., the Infection Preventionist (IP) indicated she expected staff to always wear the face mask covering their mouth and nose and reminders were posted at the nurses' stations. The IP stated

usage of source control mask, and appropriate use of eye protection have the potential to affect all 52 residents currently in the facility.
The NAR (NAR1) who did not complete adequate hand hygiene between serving resident meal trays and assisting a resident to eat was educated on when it is expected for staff to complete hand hygiene. This education was completed on 11/18/2021.
The Nurse (LPN5) who was not appropriately wearing her source control face mask over her mouth and nose was educated on proper usage of source control masks when she is in the facility. This education was completed on 11/17/2021.
The Director of Nursing and the Infection Preventionists conducted competency training and testing of staff on adequate techniques for hand hygiene and the importance of adequate completion of hand hygiene to help prevent the transmission of infectious diseases, including COVID-19, to other people. Training and competency testing of all staff also completed regarding appropriate eye wear, as well as donning and doffing of PPE. This training was conducted on ALL staff able to attend and to those staff providing direct care to residents, and ALL staff entering resident rooms. Staff that are not able to attend receive the education as they return to work on day of their next scheduled shift. This training was completed on 12/21/2021 and 12/22/2021.
The identified deficient practices were

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| F 880 | Continued From page 40<br>it was important to wear the face mask over the mouth and nose because airborne particles came out of nose and mouth and spread infection.<br><br>Review of the Centers for Disease Control and Prevention (CDC) "Guidance for Wearing Masks," updated 4/21/21, indicated "When you wear a mask, you protect others as well as yourself. Masks should completely cover the nose and mouth and fit snugly against the sides of face without gaps."<br><br>2. During observation of the screening process in the facility's lobby on 11/15/21, at 8:30 a.m., safety glasses and face masks were disseminated to the surveyors by administrative assistant 1. At this time, administrative assistant 1 instructed the surveyors to always wear a face mask and the safety glasses in the facility to prevent the spread of COVID-19.<br><br>During medication administration observation on 11/17/21, at 9:31 a.m., LPN4 was wearing her prescription eyeglasses with side shields attached while preparing medications to be administered to residents on the second floor.<br><br>The facility's "Community Transmission Rate" for the week of 11/15/21, indicated the county had a rate of 12.79% which indicated a high rate with a red classification.<br><br>During an interview with LPN4 on 11/17/21, at 9:35 a.m., she stated she was informed by the nurse manager that eyeglasses could be worn as eye protection if side shields were attached. LPN4 stated other staff wore them too. | F 880 | reviewed at the facility□s Quality Improvement Team Meeting held on December 21, 2021 to conduct the Root-Cause Analysis (RCA) to identify the problems that resulted in these deficient practices and to keep the deficient practices from recurring, and discover any potential gaps that may exist. The responsibility for monitoring proper hand hygiene, use of source control mask, appropriate eye protection, and appropriate donning/doffing of PPE of fellow staff members shall be the responsibility of ALL staff working in the facility.<br>The Director of Nursing, Infection Preventionists, and other facility leadership will conduct audits of appropriate hand hygiene, appropriate use of source control mask, appropriate use of approved eye protection, and donning/doffing PPE with Transmission Based Precautions. These audits will be conducted on all shifts, 4 times per week for 1 week, then 2 times per week for 1 week when compliance has been met. Audits began on December 21, 2021 and will continue as outlined until 100% compliance is met for staff. Additionally, the Director of Nursing, Infection Preventionists, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in use, as well as conducting real time audits on proper use of gowns to ensure PPE is in use. The audit results and monitoring will be reviewed with the QAPI team members at the next scheduled QAPI meeting on | |

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| F 880 | Continued From page 41<br>During an interview with the DON on 11/17/21, at 9:35 a.m., she stated all the staff were either wearing safety glasses or eyeglasses with side shields while in the facility. The DON stated she knew safety glasses and side shields for eyeglasses were not approved by the CDC and that staff should wear face shields or tight-fitting goggles while in the facility. The DON also stated she was informed via email from the Minnesota Department of Health on08/15/21, regarding acceptable eye protection. The DON further stated their community transmission rate was high, but they did not have any COVID positive residents in the facility. The DON indicated that staff could not talk to the residents and could not see to provide care to the residents when they wore the face shields or goggles. The DON also indicated she only allowed staff to wear the safety glasses and eyeglasses when there were not any residents that were COVID positive, quarantined, or suspected of having COVID in the facility.<br><br>During an interview with the administrator on 11/18/21, at 9:18 p.m., he indicated he was not aware that safety glasses were not acceptable eye protection according to CDC. The administrator stated he expected staff to wear the appropriate PPE to prevent COVID.<br><br>The CDC "Strategies for Optimizing the Supply of Eye Protection," updated 9/13/21, "The use of eyeglasses (with or without side shields or other attachments) is not an acceptable form of PPE or protection due to the need for 360-degree coverage. Eyeglasses (with or without attachments) still have gaps between a staff's face and the glasses, therefore, allowing opportunistic COVID spread via the mucous membranes. Put on eye protection (i.e., goggles | F 880 | January 11, 2022. | |

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| F 880 | Continued From page 42 | F 880 | | |

or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from splashes and sprays."

3. During dining observation on 11/15/21, at 1:07 p.m., nursing assistant registered (NAR) 1 picked up a meal tray from the kitchen counter with her bare hands then placed it on the table in front of R210 then picked up another tray with her bare hands from the kitchen counter and placed it on the table in front of R42. Next, NAR1 sat down in a chair next to R42, picked up a fork and fed R42 green beans. NAR1 did not sanitize her hands between passing the meal trays nor did she sanitize her hands before touching the resident's utensils. Continued observation revealed alcohol-based hand rub (ABHR) was available on the dining room counter and Sani-wipes were on the table in the dining room.

During an interview with the director of nursing (DON) on 11/17/21, at 10:51 a.m. stated she expected staff to perform hand hygiene before, during, and after serving food to the residents during the meal service. The DON stated staff should hand sanitize between serving trays, and hand sanitize between feeding residents. The DON also stated it was important to perform hand hygiene to prevent cross contamination.

During an interview with the Infection Preventionist (IP) on 11/17/21, at 11:14 a.m. stated staff should sanitize their hands after touching a resident's meal tray and before

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| | 245339 | A. BUILDING _____ B. WING _____ | C 11/18/2021 |

| 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 |
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| F 880 | Continued From page 43 | F 880 | | |

feeding a resident during the meal service. The IP stated staff were trained upon hire during orientation and annually on proper hand hygiene.

During an interview on 11/18/21, at 2:55 p.m., NAR1 confirmed she did not sanitize her hands after touching R42 and R210's meal tray with her bare hands and before feeding R42. NAR1 stated she did not normally deliver the meal trays to the residents so she was not aware that she should hand sanitize after touching the trays. NAR1 also stated she washed her hands prior to feeding residents and used the Sani wipes to clean her hands between feeding the residents. NAR1 further stated that not performing hand hygiene could cause transmission of germs from one tray to another. She stated that ABHR was located on the dining room counter, and she had some hand sanitizer in her pocket that she could have used to clean her hands.

During an interview on 11/18/21, at 8:07 p.m., NAR5 stated she washed her hands or used ABHR prior to assisting with the meal service, used hand sanitizer after she touched the meal tray with bare hands, and used the Sani-wipe after feeding residents. NAR5 stated she had the hand sanitizer clipped to her scrub top, hand sanitizer was located in each dining room on the counter, and Sani-wipes were located on each dining room table. NAR5 also stated it was important to perform hand hygiene during the meal service to prevent the spread of infection.

Review of the facility's policy titled, "Food Handling," undated, indicated food handlers must wash their hands after handling soiled equipment or utensils and after engaging in other activities that contaminate the hands.

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DEPARTMENT OF HEALTH

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

Electronically delivered
December 8, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: TWZ411

Dear Administrator:

The above facility was surveyed on November 15, 2021 through November 18, 2021 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 only a suggestion 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 11/15/21, through 11/18/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed | 2 000 | | |

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| 2 000 | Continued From page 1<br>these orders and identify the date when they will be completed.<br><br>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.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. | 2 000 | | |

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| 2 000 | Continued From page 2<br>THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 302 | MN State Statute 144.6503 Alzheimer's disease or related disorder train<br><br>ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING:<br>MN St. Statute 144.6503<br><br>(a) If a nursing facility serves persons with Alzheimer's<br>disease or related disorders, whether in a segregated or general unit, the facility's direct care staff<br>and their supervisors must be trained in dementia care.<br><br>(b) Areas of required training include:<br>(1) an explanation of Alzheimer's disease and related disorders;<br>(2) assistance with activities of daily living;<br>(3) problem solving with challenging behaviors; and<br>(4) communication skills.<br>(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.<br>(d) The facility shall document compliance with this section.<br><br>This MN Requirement is not met as evidenced by: | 2 302 | | 12/22/21 |

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| 2 302 | Continued From page 3<br><br>Based on interview and document review, the facility failed to ensure 2 of 5 newly hired staff (dietary aide [DA]-2 and activity assistant [AA]-2) had completed the required Alzheimer's and dementia care training program. This had the potential to affect all 56 residents in the facility.<br><br>Findings include:<br><br>DA-2's personal file indicated 7/8/21, as the date of hire. DA-2's Healthcare Academy training record indicated DA-2 completed education regarding problem solving with challenging behaviors on 11/13/21. There was no indication that DA-2 completed required training areas for communication skills, assistance with activities of daily living (ADLs), and an explanation of Alzheimer's disease and related disorders.<br><br>AA-2's personal file indicated 8/3/21, as the date of hire. AA-2's employee record lacked evidence of having received the required Alzheimer's training.<br><br>On 11/18/21, the Infection Preventionist (IP), who was managing this responsibility, stated new employees were supposed have completed their required Alzheimer's training and confirmed DA-2 and AA-2 had not completed the required training. Additionally, the IP stated there was no process in place to ensure Alzheimer's training had been completed.<br><br>Although requested, no policy related to Alzheimer's training was provided.<br><br>SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures related to the required Alzheimer's training program requirements. The | 2 302 | 2302: Corrected | |

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| 2 302 | Continued From page 4<br>quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 302 | | |
| 2 545 | MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency<br><br>Subp. 3. Frequency. Comprehensive resident assessments must be conducted:<br>A. within 14 days after the date of admission;<br>B. within 14 days after a significant change in the resident's physical or mental condition; and<br>C. at least once every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and document review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS) assessment within fourteen (14) days after the facility determined, or should have determined, that there had been a significant change in the resident's physical or mental condition for 1 of 24 residents (R30).<br><br>Findings include:<br><br>The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument RAI 3.0 User's Manual, Version 1.17.1 dated October 2019, Chapter 3, page 2-23, indicated a significant change in status assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program and remains a resident at the nursing home. The | 2 545 | 2545: Corrected | 12/22/21 |

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| 2 545 | Continued From page 5 | 2 545 | | |

assessment reference date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on a resident. This is to ensure a coordinated plan of care between the hospice and nursing home are in place.

R30's Face Sheet located in the Electronic Medical Record (EMR) located under the Face Sheet tab indicated R30 was admitted to the facility on 3/30/20, with diagnoses of unspecified dementia without behavioral disturbance and heart failure.

Review of R30's quarterly MDS located in the EMR under the MDS 3.0 Assessments tab with an ARD of 9/29/21, indicated the quarterly MDS was the last comprehensive assessment completed.

R30's Service Agreement - Hospice, dated 11/02/21, provided by the facility, indicated R30 participated in the development of the agreement to receive hospice services and development of the care plan.

On 11/18/21, at 9:24 a.m. the drector of nursing (DON) stated the nurse managers were responsible for completing the MDS assessments and a SCSA should be completed within 14 days of the hospice program election. The DON confirmed a SCSA should have been completed for R30 and it should have been marked on her calendar to submit by 11/15/21, but she missed the date. The DON stated the facility didn't have a policy for the completion of MDS assessments; however, the RAI 3.0 User's Manual was used as

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| 2 545 | Continued From page 6<br>a reference when completing MDS assessments.<br><br>SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on identifying significant change. The DON or designee could develop and implement policy and procedure regarding significant changefor hospice residents. Conduct audits of residents who present with a change in condition to ensure a significant change was captured.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 545 | | |
| 21385 | MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance<br><br>Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure staff conducted hand hygiene (washed hands with soap and water or used alcohol-based hand sanitizer) during the meal service for 2 out of 2 residents (R210 and R42) reviewed during dining. Additionally, the facility failed to ensure staff properly donned personal protective equipment (PPE) and wore proper eye protection while the facility had a high community transmission rate which had the potential to affect all 55 facility residents. | 21385 | 21385 Corrected | 12/22/21 |

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| 21385 | Continued From page 7<br><br>Findings include:<br><br>1. During medication administration observation on 11/16/21, at 7:16 p.m., licensed practical nurse (LPN)-5 was wearing the face mask below her nose while walking in hallway to the medication cart on the second floor. Continued observation at the second-floor nurses' station at this time revealed a sign posted on the cabinet that stated, "Effective immediately all staff and visitors are required to wear surgical style face masks and eye protection inside [facility] (regardless of vaccination status) 7/19/21, SS, RN."<br><br>During an interview with LPN5 on 11/16/21 at 7:30 p.m., LPN5 confirmed that she was wearing the face mask below her nose. LPN5 stated the mask slipped down on her nose due to the safety glasses pushing on the face mask. LPN5 stated she had been trained to wear the mask over her nose and below her chin. LPN5 stated the importance of wearing the mask over her nose was to not spread germs by droplets to the residents and other staff.<br><br>During an interview on 11/17/21, at 11:54 a.m., the Infection Preventionist (IP) indicated she expected staff to always wear the face mask covering their mouth and nose and reminders were posted at the nurses' stations. The IP stated it was important to wear the face mask over the mouth and nose because airborne particles came out of nose and mouth and spread infection.<br><br>Review of the Centers for Disease Control and Prevention (CDC) "Guidance for Wearing Masks," updated 4/21/21, indicated "When you wear a mask, you protect others as well as yourself. Masks should completely cover the nose | 21385 | | |

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| 21385 | Continued From page 8<br>and mouth and fit snugly against the sides of face without gaps."<br><br>2. During observation of the screening process in the facility's lobby on 11/15/21, at 8:30 a.m., safety glasses and face masks were disseminated to the surveyors by administrative assistant 1. At this time, administrative assistant 1 instructed the surveyors to always wear a face mask and the safety glasses in the facility to prevent the spread of COVID-19.<br><br>During medication administration observation on 11/17/21, at 9:31 a.m., LPN4 was wearing her prescription eyeglasses with side shields attached while preparing medications to be administered to residents on the second floor.<br><br>The facility's "Community Transmission Rate" for the week of 11/15/21, indicated the county had a rate of 12.79% which indicated a high rate with a red classification.<br><br>During an interview with LPN4 on 11/17/21, at 9:35 a.m., she stated she was informed by the nurse manager that eyeglasses could be worn as eye protection if side shields were attached. LPN4 stated other staff wore them too.<br><br>During an interview with the DON on 11/17/21, at 9:35 a.m., she stated all the staff were either wearing safety glasses or eyeglasses with side shields while in the facility. The DON stated she knew safety glasses and side shields for eyeglasses were not approved by the CDC and that staff should wear face shields or tight-fitting goggles while in the facility. The DON also stated she was informed via email from the Minnesota Department of Health on08/15/21, regarding | 21385 | | |

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| 21385 | Continued From page 9 | 21385 | | |

acceptable eye protection. The DON further stated their community transmission rate was high, but they did not have any COVID positive residents in the facility. The DON indicated that staff could not talk to the residents and could not see to provide care to the residents when they wore the face shields or goggles. The DON also indicated she only allowed staff to wear the safety glasses and eyeglasses when there were not any residents that were COVID positive, quarantined, or suspected of having COVID in the facility.

During an interview with the administrator on 11/18/21, at 9:18 p.m., he indicated he was not aware that safety glasses were not acceptable eye protection according to CDC. The administrator stated he expected staff to wear the appropriate PPE to prevent COVID.

The CDC "Strategies for Optimizing the Supply of Eye Protection," updated 9/13/21, "The use of eyeglasses (with or without side shields or other attachments) is not an acceptable form of PPE or protection due to the need for 360-degree coverage. Eyeglasses (with or without attachments) still have gaps between a staff's face and the glasses, therefore, allowing opportunistic COVID spread via the mucous membranes. Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from splashes and sprays."

3. During dining observation on 11/15/21, at 1:07 p.m., nursing assistant registered (NAR) 1 picked

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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307 |

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up a meal tray from the kitchen counter with her bare hands then placed it on the table in front of R210 then picked up another tray with her bare hands from the kitchen counter and placed it on the table in front of R42. Next, NAR1 sat down in a chair next to R42, picked up a fork and fed R42 green beans. NAR1 did not sanitize her hands between passing the meal trays nor did she sanitize her hands before touching the resident's utensils. Continued observation revealed alcohol-based hand rub (ABHR) was available on the dining room counter and Sani-wipes were on the table in the dining room.

During an interview with the director of nursing (DON) on 11/17/21, at 10:51 a.m. stated she expected staff to perform hand hygiene before, during, and after serving food to the residents during the meal service. The DON stated staff should hand sanitize between serving trays, and hand sanitize between feeding residents. The DON also stated it was important to perform hand hygiene to prevent cross contamination.

During an interview with the Infection Preventionist (IP) on 11/17/21, at 11:14 a.m. stated staff should sanitize their hands after touching a resident's meal tray and before feeding a resident during the meal service. The IP stated staff were trained upon hire during orientation and annually on proper hand hygiene.

During an interview on 11/18/21, at 2:55 p.m., NAR1 confirmed she did not sanitize her hands after touching R42 and R210's meal tray with her bare hands and before feeding R42. NAR1 stated she did not normally deliver the meal trays to the residents so she was not aware that she should hand sanitize after touching the trays. NAR1 also stated she washed her hands prior to feeding

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residents and used the Sani wipes to clean her hands between feeding the residents. NAR1 further stated that not performing hand hygiene could cause transmission of germs from one tray to another. She stated that ABHR was located on the dining room counter, and she had some hand sanitizer in her pocket that she could have used to clean her hands.

During an interview on 11/18/21, at 8:07 p.m., NAR5 stated she washed her hands or used ABHR prior to assisting with the meal service, used hand sanitizer after she touched the meal tray with bare hands, and used the Sani-wipe after feeding residents. NAR5 stated she had the hand sanitizer clipped to her scrub top, hand sanitizer was located in each dining room on the counter, and Sani-wipes were located on each dining room table. NAR5 also stated it was important to perform hand hygiene during the meal service to prevent the spread of infection.

Review of the facility's policy titled, "Food Handling," undated, indicated food handlers must wash their hands after handling soiled equipment or utensils and after engaging in other activities that contaminate the hands.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards for PPE and hand hygiene are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION:

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| 21385 | Continued From page 12<br>Twenty-One (21) Days. | 21385 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the second step of a two-step tuberculin skin test (TST), IGRA (interferon-gamma release assay blood test) or a chest x-ray was completed for 2 of 6 employees (licensed practical nurse [LPN]-6 and dietary aide [DA]-2) reviewed for tuberculosis (TB) screening as directed by the Centers for Disease Control and Prevention. Additionally, the facility failed to | 21426 | 21426 Corrected | 12/22/21 |

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perform a Facility TB Risk Assessment on an annual basis as directed by the Minnesota Department of Health (MDH); this had the potential to affect all 56 residents residing in the facility.

Findings include:

LPN-6 was hired 9/24/21, and received the first step TST on 9/27/21. LPN-6 had the TST read on 9/30/21, with 0-millimeter (mm) induration and a negative reading. LPN-6 had no additional TST, IGRA, or chest x-ray documentation.

LPN-6's TB Screening Tool for Health Care Workers (HCW) dated 9/27/21, indicated no symptoms of TB and LPN-6 had not had a TST in the past 12 months. A note attached to the TB Screening Tool for HCWs, undated, indicated "Reminder provided to this employee by Infection Preventionist (IP) on 10/21 and 11/17".

LPN-6's Timesheet, printed 11/18/21, indicated LPN-6 worked an average of 40 hours per week from 10/4/21, to 11/6/21.

DA-2 was hired 6/7/21, and received the first step TST on 8/17/21. However, DA-A did not have the 1st TST read within the 48-to-72 hour timeframe, and in fact, it was not read at all. DA-2 had no additional TST, IGRA, or chest x-ray documentation.

DA-2's TB Screening Tool for HCWs dated 7/8/21, indicated no symptoms of TB and DA-2 had not had a TST in the past 12 months. A note attached to the TB Screening Tool for HCWs, undated, indicated "Reminders provided to this employee by IP on 8/16 and 10/21".

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| 21426 | Continued From page 14<br><br>DA-2's Timesheet, printed 11/18/21, indicated DA-2 worked an average of 12 hours per week from 6/13/21, to 11/14/21.<br><br>On 11/15/21, the facility provided a TB assessment dated 9/18/18. In addition provided 12/9/20, which indicated the last TB risk assessment was conducted 9/18/18.<br><br>On 11/16/21, at 11:21 a.m. the Infection Preventionist (IP) provided a Facility TB Risk Assessment date completed 11/16/21. IP stated she "backdated" the 12/9/20, Facility TB Risk Assessment that was provided on 11/15/21. The IP stated she did this to indicate the assessment was completed 12/9/20; however, she did not do it on 12/9/20, but did it at a later date. IP stated she knew it was wrong to "backdate" the document. The IP stated she completed a new the risk assessment today [11/16/21], and she knew it was late.<br><br>The Facility TB Risk Assessment, completed 11/16/21, indicated "noted to be out of compliance in Summer 2021 and completed TB assessment at that time back-dating assessment", and "annual assessment was out of compliance and not completed annually related to staffing shortages and increased duties with COVID. Annual assessment to be completed in November each year by Infection Preventionist."<br><br>On 11/18/21, the IP stated new employees were supposed have received their first TST when they attended the "Day One Orientation"; instead "human resources [HR] just put them on the floor" without IP's knowledge. The IP further stated she had a process in place, but that the process had not been followed by others. Additionally, IP stated that TB testing needed to be done before | 21426 | | |

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| 21426 | Continued From page 15<br>staff started working with residents.<br><br>The facility Tuberculosis Screening - Employees policy updated 5/2018, indicated "it is the policy of this facility that all healthcare workers be tested for tuberculosis upon hire and per Minnesota Department of Health (MDH) regulations thereafter, unless contraindicated". The policy further indicated "new employees will not be allowed to work until the TST, IGRA (interferon-gamma release assay blood test) and/or check x-ray results are known".<br><br>A Facility TB Risk Assessment policy was requested, and none was provided.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the assessment process for employees to be sure the documentation of the tuberculin screens and tests are completed. The director of DON or designee could review the facility TB risk assessment to be sure the documentation is completed annually. The DON or designee could monitor for compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | | |
| 21495 | MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services<br><br>Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. | 21495 | | 12/22/21 |

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| 21495 | Continued From page 16<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide medically related social services to 1 of 1 residents (R40). The failed practice caused R40 psychological harm, in that R40 experienced ongoing anxiety and frustration when she was not allowed to fulfill her duties as R54's legal guardian.<br><br>Findings include:<br><br>R40's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/20/21, indicated a Brief Interview of Mental Status (BIMS) score of 15, which indicated she was cognitively intact, and a Personal Health Questionnaire, 9th version (PHQ-9) score of 0, indicating no depression present.<br><br>R40's quarterly MDS assessment with an ARD of 7/16/21, indicated a BIMS score of 15, and a PHQ-9 score of 4, which indicated minimal depression present.<br><br>R40's post-hospitalization re-admission MDS with an ARD of 9/27/21, indicated a BIMS of 15 and a "PHQ-9" score of 0. A significant change of condition MDS with an ARD of 10/20/21, also indicated a BIMS of 15 and a PHQ-9 score of four. Specifically, on the 10/20/21, PHQ-9, R40 reported feeling down, depressed, and hopeless at least once; and that she had failed or let her family down at least half of the time.<br><br>R40's guardianship documents provided by the facility, and a second identical set provided by R40, indicated R40 was appointed co-guardian of | 21495 | 21495 Corrected | |

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| 21495 | Continued From page 17<br>R54 on 11/21/18, along with another individual; and again, with a new co-guardian appointed on 09/28/21.<br><br>Review of the floor plan and census list provided by the facility on 11/15/21, indicated R40 and R46 (R40's husband) lived on the first floor of the facility and R54 lived on the second floor.<br><br>In an interview on 11/15/21, at 2:51 p.m. R40 became tearful when asked about her treatment in the facility. R40 reported that she had a sister, R54, who had suffered an anoxic brain injury at birth and functioned at a cognitive level comparable to a 5-year-old, who also resided in the facility. R40 stated that she and her husband (R46) had been R54's co-guardians for over 50 years. R40 stated that when R46 was diagnosed with dementia, she obtained a new co-guardian. R40 stated that beginning in January 2021, following a hospital stay in which R40 experienced some delirium, the facility had stopped allowing her to make decisions on R54's behalf or participate in R54's plan of care. R40 stated that the facility cited various reasons as to why they were implementing those restrictions, including the delirium she experienced while acutely ill, an assertion that R40 was interfering in R54's care, and R40's visual deficits. R40 reported that the facility did not inform her that they were utilizing the co-guardian to make decisions, and the co-guardian did not open financial mail which placed both R40 and R54 at risk of not having a funding source for the nursing home. R40 stated that, on her own, she hired an attorney and went back to court to establish a new co-guardian for R54. The new co-guardian was a third sister, family member (FM)1.<br><br>In continued interview with R40 on 11/15/21, at | 21495 | | |

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| 21495 | Continued From page 18<br><br>2:51 p.m. R40 stated her most pressing concern was moving R54 to the same floor as she and R46, as when the facility implemented visitation restrictions necessary for COVID-19 outbreaks, they limited residents to the floor where they each lived. R40 stated she understood why the facility had to implement these restrictions, but it meant there were extended periods of time when R54 did not have any family contact. R40 stated she had started making these requests many months ago, because in 2020 the family ended up spending both Thanksgiving and Christmas apart. R40 stated that she was becoming increasingly distressed and frustrated as the holidays approached again, because if there was another COVID-19 outbreak they might be separated for yet another holiday. R40 stated that also important, but to a lesser degree, was that she had made specific care plan requests for approaches and effective communication with R54. R40 stated that the facility refused to implement these approaches. R40 stated that she had spoken with the facility's administrator, director of nursing (DON) and social workers regarding these concerns, but they told her what happened to R54 was "not your concern." R40s stated that she had involved the Ombudsman as an advocate in the situation, and the Ombudsman agreed with all R40's concerns; but the facility refused to act upon the Ombudsman's recommendations. R40 stated that the Ombudsman had offered to help her find alternative placement for the family, but none of them wanted to do that. R40 stated that they had chosen this facility because it was affiliated with their faith and had daily spiritual support.<br><br>In an interview on 11/16/21 at 12:13 p.m., R40 stated FM1, who was R54's co-guardian, was in another state with one of their brothers, who was | 21495 | | |

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on hospice care and nearing the end of his life. R40 stated that the facility was waiting for FM1 to return before moving R54 to the same floor as R40 and R46. R40 stated that the facility felt this was because FM1 did not agree with the room move, but the facility's perceptions were incorrect. R40 stated, "That's a blatant lie. [FM1] wants [R54] moved to be with [R46] and me. I have fought this for so many months. It's all I think about."

In an interview on 11/16/21, at 1:24 p.m. the director of social services (DSS) stated she was aware of R40's status as R54's legal guardian, which the DSS stated meant R40 had the authority to make health care and placement decisions on R54's behalf. The DSS stated that "a year or so ago" R40 was hospitalized, and it was determined she had a cognitive deficit at that time. The DSS stated that R40 agreed to have a co-guardian for R54 at that time, then became upset when the co-guardian did not make the care decisions R40 felt were appropriate, such as moving R54 to the first floor, and did not follow through with information requests to secure Medicaid. The DSS stated that the facility felt R40 was not making decisions based on R54's best interests, so the facility had refused to honor R40's requests they felt violated R54's rights. The DSS stated that R40's visual deficit made it difficult for her to be independent and combined with her cognitive deficits impaired her ability to serve as R54's guardian. The DSS stated that after R40's hospitalization in January 2021, her cognition "seems to have cleared" and could not cite evidence of a current cognitive deficit. The DSS was unable to state how R40's visual deficit impacted her ability to fulfill her duties as R54's legal guardian. The DSS stated that FM1, who was R54's co-guardian, agreed with the facility's

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assessment that R40 was not making decisions in R54's best interest and wanted to talk to R54 before anything was changed. The DSS stated that after making this known to facility staff, FM1 "went on vacation or something, and left without doing anything about it. There's nothing we can do until she comes back, and she didn't tell us when that was going to be." The DSS stated that the Ombudsman was involved and supported the facility's decision to delay moving R54 until FM1 returned and spoke to R54 independently.

In an interview on 11/16/21, at 2:36 p.m., social worker (SW)-1 stated she was familiar with R40 and knew that R40 was R54's guardian. SW1 stated that R40 was "manipulative and controlling" towards R54. When asked for details of this assessment, SW1 stated that R40 had seen staff serving R54 both chocolate milk and hot chocolate prior to a meal and told staff to offer R54 one or the other until she had been presented with her meal, though staff knew R54 liked both items. SW1 stated that based on these types of interactions, the facility had determined R40 was making "inappropriate" decisions for R54. SW1 also stated that R40 had cognitive deficits which interfered with her ability to serve as R54's guardian. SW1 stated that the facility had not notified either R40's physician of their concern with her cognition or notified the court that they were concerned with R40's ability to carry out her court-appointed duties as guardian.

In an interivew on 11/16/21, at 5:54 p.m., the ombudsman stated R40 had contacted her to ask her to advocate for R54 and R40. The Ombudsman stated she understood the facility was concerned with the decisions R40 was making but encouraged the facility to defer to R40 as R54's guardian. The Ombudsman stated that

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| 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) COMPLETE DATE |
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| 21495 | Continued From page 21<br><br>R54's current co-guardian (FM1) was in support of the decisions R40 was making and recommended to the facility that they follow those wishes. The Ombudsman stated she was not confident that the facility planned to listen to R40 and FM1. The Ombudsman stated that she had not noticed any obvious cognitive deficits for R40 during their interactions.<br><br>When asked in an interview on 11/16/21, at 6:26 p.m. R40 stated that there was no disagreement between her and FM1 as far as the request for R54 to move nearer to her or the input she had for R54's care. R40 stated, "Please call [FM1] and ask her. I don't know why they [the facility] has been so gruesome in their treatment of me." R54 expressed concern that facility leadership, specifically the DON and administrator, would retaliate against her for reporting to the survey team by further restricting her access to R54.<br><br>In an interview with registered nurse (RN) nurse manager 2 on 11/17/21, at 8:20 a.m., she stated that she was the unit manager for the first floor, where R40 and R46 resided. RN Nurse Manager 2 stated that she was aware that R40 was R54's guardian and the facility's concern with her making decisions on R54's behalf. RN Nurse Manager 2 described R40 as "forgetting things that happened when she was sick, and a couple of other things like that" but had not been concerned with R40's cognition to the point that she felt they needed to notify the physician for further work-up. RN Nurse Manager 2 stated, "I said months ago that they should just move her [R54] down here, but for some reason they just don't want to."<br><br>In an interview on 11/17/21, at 12:21 p.m., R40's physician (MD) stated R40 had not been | 21495 | | |

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| | 00634 | A. BUILDING: _____ B. WING _____ | C 11/18/2021 |

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| MOTHER OF MERCY SENIOR LIVING | 230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307 |

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| 21495 | Continued From page 22 | 21495 | | |

diagnosed with a cognitive deficit. The MD stated that a year ago R40 had experienced a delirium during a hospitalization but had since cleared and returned to baseline. The MD stated that R40 did not have a cognitive deficit, or any other deficits, which would preclude her from fulfilling her duties as guardian. The MD stated he knew R40 had been R54's guardian for "decades" and there had never been any concerns brought to his attention. The MD stated that he was aware of the conflict R40 had had with the facility regarding this issue. The MD stated, "[R40] has depression and anxiety at baseline and this hasn't helped, that's for sure. In my opinion you pick your battles carefully and why they picked this one is beyond me."

In an interview on 11/17/21, at 12:55 p.m. the DSS and SW1 both stated the facility did not have a policy on the provision of medically-related social services.

In an interview on 11/17/21, at 1:28 p.m. the administrator stated he was aware R40 was the legal guardian for R54. When asked about a guardian's role, the administrator stated, "If a resident has an assigned guardian, we would have to basically honor their wishes, if the request was reasonable and the guardian was competent to ask for those things." The administrator stated that he would have to defer to "clinical" to determine if requests were reasonable, and to "legal" to determine if a guardian was competent to make requests. The administrator described R40 as being "very domineering," citing again the example with hot chocolate and chocolate milk SW1 had previously mentioned. The administrator verified the facility lacked a policy on the provision of medically related social services.

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| 21495 | Continued From page 23<br><br>In an interview on 11/17/21, at 4:12 p.m. FM1 confirmed that R40 had been R54's guardian for at least 40 years. FM1 stated, "I defer to [R40] completely. I could tell in the last meeting we had that they were not going to move [R54] even though both [R40] and I thought it was fine. Even though they said they talked to [R54] I just don't trust that they are asking her [R54, regarding the room move] in a way she understands. I have known [R40] and [R46] to make wise and loving decisions for [R54]. I defer completely." FM1 described the facility's failure to allow R40 to fulfill her duties as guardian as, "Hard on her. Very hard. I think she's started to feel some of the staff are dismissive and rude. It's caused her a lot of anxiety, a lot of worry."<br><br>An interview with R40 on11/17/21 at 4:46 PM revealed, "You can't imagine what I have been through over the past year. The facility has tried to convince so many people I'm incapacitated. They have abused me with this, I can't deny that. There's no one I could talk to." R40 stated that she had been told by the social workers, nurses, and Administrator that it was the DON who would ultimately make the decision about whether to allow her to fulfill her duties as R54's legal guardian.<br><br>In an interview on 11/17/21, at 5:42 p.m. the DON stated she had stepped into her current role a month and a half ago but was familiar with the situation due to her previous position at the facility. The DON stated that she presumed the social workers and administrator were overseeing their concerns and she had concentrated on clinical issues rather than psychosocial ones. The DON stated that she was "horrified" to learn that R40 was feeling ignored and abused by the | 21495 | | |

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| 21495 | Continued From page 24<br>situation. The DON stated, "I've known [R40] for a long time. As far as I'm concerned, we can move [R54] any time. I've thought that since the beginning, but by the time I became the DON everyone had their heels dug in against the move, so I haven't been able to make it happen."<br><br>SUGGESTED METHOD OF CORRECTION: The social services director or designee could develop, review, and/or revise policies and procedures to ensure all residents pyschosocial needs are being met and that they are receiving medically related social services . The social services director or designee could educate all appropriate staff on the policies and procedures. The social services director or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 21495 | | |
| 21615 | MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII<br><br>Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure controlled medications (drugs that can cause physical and mental dependence and have restrictions on how | 21615 | 21615 Corrected | 12/22/21 |

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they can be filled and refilled) were stored securely on 3 of 3 medications carts. Specifically, the scheduled III, IV, and V medications were not stored in the locked drawer on the cart. Additionally, the facility failed to ensure controlled medications for 3 of 3 residents (R22, R48 and R45) were stored securely in 2 of 3 medication storage rooms (on the first and second floors) in that the locked box for controlled medications in the refrigerator was not permanently affixed to the refrigerator. This had the potential to affect all 56 residents who resided in the facility.

Findings include:

During an observation on 11/16/21, at 3:02 p.m. licensed practical nurse (LPN)-3 showed the medication cart located on the third floor contained the following schedule IV and V medications in drawer above the locked drawer:
1. 18 tablets of lorazepam (schedule IV medication) 0.5 milligrams (mg) for R22;
2. 22 tablets of tramadol (schedule IV medication) 50 mg for R48; and
3. 24 tablets of Vimpat (schedule V medication) 50 mg and 50 tablets of Vimpat (schedule V medication) 100 mg for R45.

In an interview on 11/16/21, at 3:05 p.m. LPN3 stated the schedule II medications were stored in the locked drawer in the medication cart, but the schedule III, IV and V medications were stored in a pull-out drawer located above the locked compartment where the schedule II medications were stored. LPN3 stated, to prevent drug diversion, only the nurses that were assigned the medication carts had keys to the cart and medication room.

In an interview on 11/17/21, at 10:24 a.m. the

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director of nursing (DON) stated she had discussed the storage of scheduled medications with the Pharmacy Consultant when the State Operations Manual (SOM) Appendix PP Guidance to Surveyors for Long Term Care Facilities was revised in 2017. The DON stated scheduled medications had to be stored under a two locked system. The DON stated the medication cart had a lock on it and the drawer in the medication cart had a lock on it which the schedule II medications were stored and only the nurses that were assigned to the medication carts had keys to the locks. The DON further stated she did not know why the schedule III, IV and V medications were not stored in the same locked drawer as the schedule II medications. The DON indicated the facility had cameras in the hallways on all floors that could be viewed to identify drug diversion.

In an interview on 11/18/21, at 6:55 p.m. registered nurse (RN) Manager1 stated she was not aware that all scheduled medications had to be stored under a double locked system. RN Manager1 stated the schedule III, IV and V medications were not stored in a locked drawer on the cart, but the medication cart was locked. RN Manager1 stated only the nurses assigned to the carts had keys to the cart and the nurses counted the scheduled medications at shift change. RN Manager1 further stated she reviewed the medication administration records (MAR) of the residents daily and the nurses were required to report any missing scheduled medications at shift change which had not happened while she was the manager.

During an interview on 11/19/21, at 2:30 p.m., the Pharmacy Consultant stated the scheduled medication storage regulation stated only

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schedule II medications had to be double locked; not the schedule III, IV, and V medications. The Pharmacy Consultant stated the facility was following the regulation because they were storing schedule II drugs in a locked drawer that was permanently affixed to the medication cart. During observation and interview 11/17/21, at 3:56 p.m. with licensed practical nurse (LPN)-7, the second-floor locked medication cart and locked medication room were reviewed. The medication cart had a separately locked, permanently affixed compartment which contained medications classified as Schedule II controlled drugs. The Schedule III, IV, and V controlled medications were observed in a drawer that did not have a separate lock. LPN-7 stated the controlled medications were stored per facility policy with only the Schedule II controlled medications separately locked "because they're stronger". A locked medication refrigerator was in the medication room. Located on a shelf of the refrigerator were four prescription labeled boxes of lorazepam concentrate (a medication used to manage anxiety). LPN-7 stated the medication refrigerator did not contain a separately locked, permanently affixed compartment.

During observation and interview 11/18/21, at 10:19 a.m. with registered nurse (RN)-1, the first-floor locked medication cart and locked medication room were reviewed. The medication cart had a separately locked, permanently affixed compartment which contained all classifications of controlled medications. RN-1 stated the Schedule III, IV, and V controlled medications were kept in a drawer that did not have a separate lock, but she "got an email to move the Schedule III, IV, and V's to the locked drawer". The locked medication room contained a locked medication refrigerator. Located on a shelf in the

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refrigerator were six prescription labeled boxes of lorazepam concentrate. RN-1 confirmed the medication refrigerator did not contain a separately locked, permanently affixed compartment.

The facility's Controlled Drug Policy and Procedure revised 11/17/21, indicated "a separate locked compartment for Schedule II drugs is provided within medication carts and in the med room fridges. The compartments have a special lock and key and must be kept locked at all times". However, the policy failed to address the storage of Schedule III, IV, and V controlled medications.

The facility's Medication Orders policy dated 8/18, indicated "IB2: Controlled Substance Prescriptions. L. Controlled substance medications are stored at the facility under double lock on the medication cart separate from all other medications and counted at each change of custody. The access key to controlled medications is not the same key that allows access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. Back-up keys to all medication carts may be obtained from the provider pharmacy. Controlled medications kept in the refrigerator must be double locked with lock on refrigerator and lock on the med [medication] room door."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON), or designee, could review all refrigerators used to store controlled medications to ensure appropriate locking devices are attached and secured; review all medication carts used to store controlled medications to ensure all controlled medication

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| 21615 | Continued From page 29<br>are stored in a locked area; then inservice staff on applicable policies and procedures for the storage of these medications. They could then audit to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21615 | | |
| 21942 | MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils<br><br>Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to attempt to establish a family council during the past calendar year. This had the potential to affect all 56 residents in the facility<br><br>Findings include:<br><br>On 11/17/21, at 12:40 p.m. the director of social services (DSS) stated no attempts had been made to contact resident families regarding the offering of a family council within the past year. The DSS stated the facility had not offered any | 21942 | 21942 Corrected | 12/22/21 |

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| 21942 | Continued From page 30<br>meetings.<br><br>On 11/17/21, at 1:57 p.m. the administrator stated he understood the offering of a family council was required.<br><br>Although requested, no policy related to family council was provided.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could review facility systems for family council and work on promotion and encouragement of this group on an annual basis.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21942 | | |

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| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety re-certification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/17/2021. At the time of this survey, Mother of Mercy Senior Living Building 01 Main Building, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 12/16/2021 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 000 | Continued From page 1<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Building 01 Main Building:<br>Mother of Mercy Senior Living is a 3 story building with no basement. The building was constructed at 3 different times. The original building is a 2 story building without basement that was constructed in 1983 and is determined to be of Type II(222) construction. In 1999, a 1 story addition (Welcome Center) was added to the east that was determined to be of Type V(111) construction. In 2009 the 3rd floor addition was | K 000 | | |

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| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 000 | Continued From page 2<br>added to the facility above the existing 1983 building and was was determined to be of Type II (111) construction. The facility was surveyed as two facilities.<br><br>The facility has 2 hour fire separations between the 1983, 1999, and 2009 buildings and additions. The facility has been divided and inspected as 2 separate buildings. Building 01 consists of the 1st, 2nd and the 3rd floors of the facility has two separate building construction types and is being downgraded to Type II(111), which is separated from building 02 by a 2 hour vertical fire barrier.<br><br>The building is fully sprinkler protected and has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 70 beds and had a census of 56 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 291 SS=C | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility has failed to ensure that emergency lights | K 291 | K-291: New battery was installed in the battery powered emergency light in the | 11/21/21 |

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|---|---|---|---|
| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MOTHER OF MERCY SENIOR LIVING** | **230 CHURCH AVENUE, BOX 676**<br>**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 |
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| K 291 | Continued From page 3<br>are in operable condition per NFPA 101 (2012 edition), The Life Safety Code, sections 7.9.2.3 and 19.2.9.1. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 11/17/2021 at 10:35 AM, it was revealed by observation that the battery powered emergency light located in the kitchen corridor leading to the dry storage room was inoperable when tested at the time of the inspection.<br><br>2. On 11/17/2021 at 11:05 AM, it was revealed by observation that the battery powered emergency light located in the 3rd floor medication room was inoperable when tested at the time of the inspection.<br><br>An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery. | K 291 | kitchen corridor and in the battery powered emergency lighting the third floor medication room. The lights were and light was verified to be in operating correctly.<br><br>Lights will be monitored monthly to ensure the lights are in working order to prevent the deficient practice from occurring again. This was completed on 11/21/2021. The Maintenance Director will be responsible for ensuring continued compliance. | |
| K 321 SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied | K 321 | | 11/21/21 |

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|---|---|---|---|
| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 321 | Continued From page 4<br>protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility per NFPA 101 (2012 edition), The Life Safety Code, sections 8.7.1.1, 8.7.1.3 and 19.3.2.1.3. This deficient condition could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 10:26 AM, it was revealed by observation that resident room 351 was converted from a resident room and into a storage room that is greater than 50 square feet which contains COVID-19 personal protective equipment and supplies. Upon further inspection of the converted room it was found that the door | K 321 | K321: Self-closing hinges were installed on Resident Room #351, to ensure the door is self-closing. The door was tested on 11/21/2021 and verified that it is now fully operational. The Maintenance Director will be responsible for ensuring continued regulatory compliance. | |

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|---|---|---|---|
| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 321 | Continued From page 5<br>to the room was not self-closing.<br><br>An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery. | K 321 | | |
| K 345 SS=C | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.5.2 and 14.6.2.4. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 9:56 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with Maintenance Supervisor, that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. | K 345 | K345: Semi-annual inspection of initiating device will be completed on the fire alarm system on 12/15/2021. Documentation lines have been added to the inspection sheets to verify proper operation and to maintain compliance. Maintenance Director will be responsible of ensuring compliance of initiating devices is completed. | 12/15/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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

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| K 345 | Continued From page 6<br><br>An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery. | K 345 | | |
| K 353 SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, documentation review, and staff interview, the automatic sprinkler system is not maintained per NFPA 101 (2012 edition) The Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition) the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, sections 5.2.1.1.1 and 5.2.1.1.2. This deficient finding could have an isolated impact on the residents | K 353 | K353: The sprinkler head, identified in the inspection located in the 1st floor storage room #103 that had dried paint on it, was replaced with a new sprinkler head. This was completed on 12/15/2021. The Maintenance Director and Maintenance personnel will be responsible for observing on daily rounds that sprinkler heads in the buildings are free of any | 12/15/21 |

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| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 353 | Continued From page 7<br>within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 11:09 AM, it was revealed by observation that there is a painted fire sprinkler head located on the 1st floor in storage room 103<br><br>An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery. | K 353 | debris that may impact the proper functioning of them. | |
| K 761 SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6 , and NFPA 80 (2010 edition), Standard for Fire | K 761 | K761: The Maintenance of the fire door inspections was completed on 11/22/2021 and the written records of testing and inspection are now maintained for review to show inspections occurred within the | 11/22/21 |

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| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 761 | Continued From page 8<br>Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 9:15 AM, it was revealed by a review of available fire door test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide any current documentation verifying that the fire door inspection had been completed within the last 12 months.<br><br>An interview with the Maintenance Supervisor verified this finding at the time of discovery. | K 761 | prior 12 months. The Maintenance Director will ensure continued compliance. | |
| K 901 SS=F | Fundamentals - Building System Categories CFR(s): NFPA 101<br><br>Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities | K 901 | K901: The updated Risk Assessment was updated on 11/21/2021 to now include the annotate of the facility's patient/resident care equipment to be | 11/21/21 |

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|---|---|---|---|
| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 901 | Continued From page 9<br>Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 9:30 AM, it was revealed by a review of available utility risk assessment documentation and an interview with Maintenance Supervisor, that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not annotate the facility's patient/resident care equipment to be assessed or the impact that an equipment failure would have on the patients/residents within the facility as detailed in NFPA 99 (2012 edition) Health Care Facilities Code, chapter 10 - Electrical Equipment, and chapter 11 - Gas Equipment.<br><br>An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery. | K 901 | assessed with the impact an equipment failure would have on the residents/patients with in the facility, as detailed in NFPA 99 (2012 edition). Health Care Facilties Code, Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. The Maintenance Director will be responsible for ensuring compliance is maintained for this documentation. | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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 | K 918 | | 12/1/21 |

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| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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| K 918 | Continued From page 10<br>transfer switches are performed in accordance with NFPA 110.<br>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 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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator per NFPA 101 (2012 edition), The Life Safety Code, sections, 9.1.3 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include: | K 918 | K918: The Emergency Generator Test Log now has a line added to verify and document that the Emergency Generator is tested at 30% load or more of the generator Kilowatt rating. The Maintenance Director will be responsible for maintaining the testing and documentation in the Emergency Generator Test Log.<br>This was completed on December 1, 2021. | |

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| | 245339 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/17/2021** |

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|---|---|---|---|---|
| K 918 | Continued From page 11<br>On 11/17/2021, at 10:07 AM, it was revealed by a review of available fire door test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide or document information verifying that the emergency generator had be tested monthly at 30 percent of the generator Kilowatt rating.<br><br>An interview with the Maintenance Supervisor verified these findings at the time of discovery. | K 918 | | |

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|---|---|---|---|
| | 245339 | A. BUILDING **02 - 3RD FLOOR ADDITION**<br>B. WING _____ | **11/17/2021** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety re-certification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/17/2021. At the time of this survey, Mother of Mercy Senior Living Building 02 (Welcome Center), was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/16/2021 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 245339 | A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____ | **11/17/2021** |

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| K 000 | Continued From page 1 | K 000 | | |

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

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 detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Building 02 (Welcome Center):
Mother of Mercy Senior Living is a 3 story building with no basement. The building was constructed at 3 different times. The original building is a 2 story building without basement that was constructed in 1983 and is determined to be of Type II(222) construction. In 1999, a 1 story addition (Welcome Center) was added to the east that was determined to be of Type V(111) construction. In 2009 the 3rd floor addition was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245339 | A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____ | **11/17/2021** |

| 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 |
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| K 000 | Continued From page 2<br>added to the facility above the existing 1983 building and was was determined to be of Type II (111) construction. The facility was surveyed as two facilities.<br><br>The facility has 2 hour fire separations between the 1983, 1999, and 2009 buildings and additions. The facility has been divided and inspected as 2 separate buildings. Building 02 consists of the 1999 Welcome Center addition, located on the east wall of the 2nd floor and is determined to be of type V(111).<br><br>The building is fully sprinkler protected and has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 70 beds and had a census of 56 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 345 SS=C | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 | K 345 | | 12/15/21 |

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| K 345 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.5.2 and 14.6.2.4. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 9:56 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with Maintenance Supervisor, that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed.<br><br>An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery. | K 345 | K345: Semi-annual inspection of initiating device will be completed on the fire alarm system on 12/15/2021. Documentation lines have been added to the inspection sheets to verify proper operation and to maintain compliance. Maintenance Director will be responsible of ensuring compliance of initiating devices is completed. Testing and maintaining of the Fire Alarm system will be documented to verify that inspection has been completed. | |
| K 761 SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience | K 761 | | 11/22/21 |

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| K 761 | Continued From page 4<br>that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6 , and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 9:15 AM, it was revealed by a review of available fire door test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide any current documentation verifying that the fire door inspection had been completed within the last 12 months.<br><br>An interview with the Maintenance Supervisor verified this finding at the time of discovery. | K 761 | K761: The Maintenance of the fire door inspections was completed on 11/22/2021 and the written records of testing and inspection are now maintained for review to show inspections occurred within the prior 12 months. The Maintenance Director will ensure continued compliance. | |
| K 901 SS=F | Fundamentals - Building System Categories<br>CFR(s): NFPA 101<br><br>Fundamentals - Building System Categories<br>Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure | K 901 | | 11/21/21 |

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| K 901 | Continued From page 5<br>performed by qualified personnel.<br>Chapter 4 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/17/2021, at 9:30 AM, it was revealed by a review of available utility risk assessment documentation and an interview with Maintenance Supervisor, that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not annotate the facility's patient/resident care equipment to be assessed or the impact that an equipment failure would have on the patients/residents within the facility as detailed in NFPA 99 (2012 edition) Health Care Facilities Code, chapter 10 - Electrical Equipment, and chapter 11 - Gas Equipment.<br><br>An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery. | K 901 | K901: The updated Risk Assessment was updated on 11/21/2021 to now include the annotate of the facility's patient/resident care equipment to be assessed with the impact an equipment failure would have on the residents/patients with in the facility, as detailed in NFPA 99 (2012 edition). Health Care Facilties Code, Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. The Maintenance Director will be responsible for ensuring compliance is maintained for this documentation. | |