Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 19, 2024

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

RE: CCN: 245339
Cycle Start Date: October 26, 2023

Dear Administrator:

On December 12, 2023, we notified you a remedy was imposed. On January 18, 2024 the Minnesota Departments 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 January 12, 2024.

As authorized by CMS the remedy of:

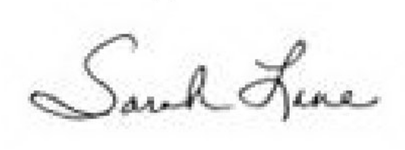
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 26, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 12, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 26, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 12, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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,



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

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January 19, 2024

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

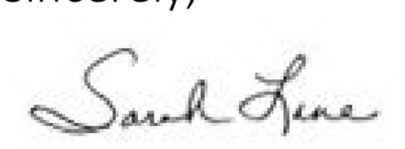
Re: Reinspection Results
Event ID: WHXZ12

Dear Administrator:

On December 12, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 26, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Electronically delivered
November 8, 2023

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

RE: CCN: 245339
Cycle Start Date: October 26, 2023

Dear Administrator:

On October 26, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 26, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 26, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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

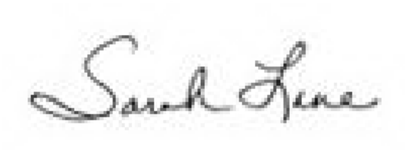
specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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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 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/23/23 through 10/26/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/23/23 through 10/26/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53396540C (MN97087), H53396582C (MN96854) 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684	Quality of Care	F 684		11/28/23

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

Electronically Signed | 11/17/2023

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

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F 684 SS=D	Continued From page 1 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the faciilty failed to notify the resident's physician of omitted medications, reason for medication omissions, and abnormal blood sugars for 1 of 2 residents (R44) reviewed for insulin. Findings include: R44's admission Minimum Data Set (MDS) dated 9/12/23, indicated R44 admitted to the facility on 9/5/23, and had severe cognitive impairment. R44's diagnoses included diabetes mellitus (DM) and Alzheimer's Disease. R44 received daily insulin injections. R44's Medication Review Report dated 10/26/23, indicated R44 was prescribed scheduled mealtime and sliding scale Humalog insulin (fast-acting insulin), and scheduled Lantus insulin (long-acting insulin). The orders lacked parameters to hold the scheduled mealtime insulin. R44's Medication Administration Record (MAR) dated 10/1/23 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/9/23	F 684	R44's provider was notified of omitted medications, reasons for medication omissions and abnormal blood sugars. The facility continues to collaborate with the provider in managing R44's blood sugars and medications and received new insulin administration parameters. All licensed nurses were educated on updating providers when holding insulin administration and appropriate documentation of correspondence on 11/17/2023. An audit was conducted of other residents that receive insulin to assure that any omitted medications, reasons for medication omissions and abnormal blood sugars were communicated to their provider. The Director of Nursing and/or designee will conduct random chart audits for residents that receive insulin to assure that any omitted doses, abnormal blood sugars, and/or resident specific reporting parameters, as appliable, are communicated to the provider. Audits will be completed three times a week for a	

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F 684	Continued From page 2 at 12:00 p.m. (Humalog 10 units). R44's progress note dated 10/9/23 at 12:58 p.m., the lunchtime dose of Humalog 10 units indicated R44's blood sugars (BS) prior to lunch was 55 and "while resident did consume lunch, BS is not coming up very quickly". The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held. R44's Medication Administration Record (MAR) dated 10/1 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/10/23 at 12:00 p.m. (Humalog 10 units). R44's progress note dated 10/10/23 at 12:40 p.m., the lunchtime dose of Humalog 10 units indicated R44's BS prior to lunch was 67 and was "slow to come up". The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held. R44's Medication Administration Record (MAR) dated 10/1 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/12/23 at 12:00 p.m. (Humalog 10 units). R44's progress note dated 10/12/23 at 1:00 p.m., the lunchtime dose of Humalog 10 units indicated R44's BS prior to lunch was 70 and was "slow to come up". The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held. R44's Medication Administration Record (MAR) dated 10/1 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/16/23 at 5:00 p.m. (Humalog 8 units).	F 684	week, two times a week for two weeks, then weekly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments	

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F 684	Continued From page 3 R44's progress note dated 10/16/23 at 6:06 p.m., indicated R44's suppertime dose of Humalog 8 units was held due to "B/P" [BS] of 53 before supper, ate well at supper". The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held. R44's Medication Administration Record (MAR) dated 10/1 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/17/23 at 12:00 p.m. (Humalog 10 units). R44's progress note dated 10/17/23 at 12:56 p.m., the lunchtime dose of Humalog 10 units indicated R44's BS before lunch was 94 and R44 "did not eat 50% of meal". The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held. R44's Medication Administration Record (MAR) dated 10/1 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/19/23 at 12:00 p.m. (Humalog 8 units). R44's progress note dated 10/19/23 at 1:27 p.m., the lunchtime dose of Humalog 8 units indicated R44's BS was 117 and R44 "did not consume much lunch". The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held. R44's Medication Administration Record (MAR) dated 10/1 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/21/23 at 5:00 p.m. (Humalog 6 units). R44's progress note dated 10/21/23 at 3:23 p.m., indicated R44's BS at 3:00 p.m. was 52, with no signs or symptoms of hypoglycemia (low blood	F 684		

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F 684	Continued From page 4	F 684		

sugar). R44 was given a banana split sunae. R44's BS was 56 at 3:25 p.m. Note indicated nurse would continue to monitor. Subsequent progress notes on 10/21/23 did not indicate R44's provider was notified R44's Humalog 6 units was held at 5:00 p.m.

R44's Medication Administration Record (MAR) dated 10/1 to 10/31/23, indicated R44's scheduled mealtime insulin was held on10/23/23 at 5:00 p.m. (Humalog 6 units).

R44's progress note dated 10/23/23 at 5:42 p.m., regarding the suppertime dose of Humalog 6 units indicated R44 did not eat enough carbohydrates for low BS from 60-82 prior to supper. The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held.

Review of R44's Medication Administration Record (MAR) dated 10/1 to 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/24/23 at 5:00 p.m. (Humalog 6 units).

R44's progress note dated 10/24/23 at 6:30 p.m. indicated R44's BS lowered to 82 at 3:40 p.m., 72 at 4:32 p.m., and 70 at 5:08 p.m. R44's BS after supper was 127. No insulin was administered for supper. The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held.

R44's Medication Administration Record (MAR) dated 10/1 through 10/31/23, indicated R44's scheduled mealtime insulin was held on 10/25/23 at 5:00 p.m. (Humalog 6 units).

R44's progress note dated 10/25/23 at 6:17 p.m.,

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F 684	Continued From page 5 regarding the evening dose of Humalog 6 units indicated R44 did not eat supper. The progress note did not indicate R44's provider was notified the scheduled mealtime dose of Humalog was held. R44's Provider Visit Progress Note dated 10/19/23, indicated nursing staff described R44 had a hypoglycemic event 10/18/23 around suppertime, was very sweaty, blood sugar was around 50, emergency glucagon was administered, and R44 responded well. R44 had tendency to have lower blood sugar readings in the early evenings, high readings during nighttime, and was relatively consistent with eating her meals. Provider decreased mealtime insulin dosing and slightly increased R44's basal insulin doseing. Nursing staff were instructed to monitor R44 closely, encourage regular meals, not miss meals, and limit snacking. Provider planned to follow up in about two weeks to review blood sugars. Provider visit progress note did not indicate staff had notified the provider scheduled mealtime insulins had been held. Parameters to hold the scheduled insulins were not addressed in the provider visit note. R44's Consulting Pharmacist summary of pharmacist identified irregularities dated 10/24/23, indicated R44's 5:00 p.m. dose of Humalog had been held twice in the past five days and the 12:00 p.m. Humalog had been held twice in the past six days. Standing orders for hypoglycemia (low blood sugar) "that staff were expected to follow" included administration of glucose, hypoglycimia symptoms present, BS checks every 15 minutes until BS >70 mg/dL, and contacting the physician. All of these steps should have been documented in a progress note.	F 684		

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F 684	Continued From page 6 Consulting Pharmacist review of R44's records revealed these expectations were not done consistently for R44. The Consulting Pharmacist summary did not address the absence of parameters to hold the scheduled mealtime insulins. On 10/25/23 at 8:33 a.m. Licensed Practical Nurse (LPN)-B stated R44's blood sugars had been very low and LPN-B had held R44's lunchtime dose of Humalog if R44 had not eaten very much or if R44 had been walking around a lot. LPN-B stated the orders did not have parameters for when insulin should be held, and had not contacted the provider prior to holding the insulin. LPN-B stated, "Okay, I've been doing it wrong then." On 10/25/23 at 2:20 p.m. the Registered Nurse Unit Manager (RN)-A stated R44 admitted to facility because R44's family could no longer manager her diabetes. RN-A stated staff should have notified the provider at the time they made the judgement to hold the scheduled mealtime insulins, it would be important because nurses are only licensed to follow provider orders, and nurses cannot write orders as it would be "beyond our scope of practice". The facility's Insulin Administration policy, approved 10/2023, indicated insulin would be administered as ordered by the provider, and any refusals would be documented and the provider would be notified.	F 684		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		11/28/23

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F 727	Continued From page 7 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to have 8 hours of consecutive registered nursing coverage on a daily basis. This had the potential to affect all 54 residents residing in the facility. Findings include: The Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report identified during the third quarter of 2023 (4/1/23 through 6/30/23) the facility failed to have registered nurse (RN) coverage for the entire quarter. The facility provided schedules for the third quarter of 2023 indicated a lack of RN coverage for 8 consecutive hours for the following dates: 4/16, 4/30, 5/7, 5/14, 5/28, 6/3, and 6/11. The facility provided schedules for week of the survey period (10/22/23 through 10/28/23) and month preceding (9/23/23 through10/23/23) indicated a lack of RN coverage for 8 consecutive	F 727	The facilities policy on "Posting of Nursing Hours - Long Term Care" was reviewed and remains current which indicates the requirement for the facility to have a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. Facility leadership and scheduling assistant have reviewed the policy and aware of the expectation. The Director of Nursing and/or designee will audit the weekly schedule to assure the RN coverage requirement is met. Audits will be completed weekly x3 weeks then monthly until the next Quality Assurance Committee; results of the audits will be reviewed with the members of the QA committee to determine the appropriateness/frequency of ongoing assessments	

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 10/26/2023

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

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F 727	Continued From page 8 hours for the following dates: 9/23, 9/24, and 10/1. During an interview on 10/25/23 at 9:40 a.m., staff scheduler (SS-E) stated that when creating the schedule, she made sure to have 24 hours of licensed nursing coverage, and 8 hours of that should be for an RN. SS-A continued that she was not aware that the eight hours of RN coverage meant the RN needed to be in the building. SS-A stated, "I thought the RN could be on call for the eight hour of weekend coverage". During an interview on 10/25/23 at 10:40 p.m., director of nursing (DON) stated there needed to be 8 hours of continuous RN coverage. She was aware of the issue on the weekends with RN coverage. Facility staff scheduling policy requested, none provided.	F 727		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		11/28/23

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F 812	Continued From page 9 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain temperature logs for refrigerators and food served. This had the potential to affect all 54 residents residing in the facility. Finding includes: During observation on 10/24/23 at 2:47 p.m., the 2nd floor kitchenette refrigerator temperature log indicated multiple missing entries. 1st and 3rd floor kitchenette refrigerator temperature logs indicated missing multiple entries as well. Facility document for refrigerator logs indicated 25 missing temperatures for 1st floor kitchenette refrigerator, 45 missing temperatures for 2nd floor kitchenette refrigerator, and 43 missing temperatures for 3rd floor refrigerator. During observation on 10/25/23 at 11:57 a.m., dietary cook (DC-A) and DC-B finished noon meal prep in the kitchen. However, did not record temperatures from meal preparation on temperature logs located on cabinets above preparation station in main kitchen. During observation on 10/25/23 at 12:08 p.m., DC-A recorded food temperatures prior to serving food for 2nd floor kitchenette. During interview on 10/25/23 at 12:08 p.m., DC-A stated she took the temps, but "often forgets" to	F 812	Dietary Manager or designee will re-educate the dietary staff on logging the results of required temperature checks. The Dietary Manager or designee will complete audits to ensure temp logs of refrigerator and food are being kept per policy. The audit observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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F 812	Continued From page 10 record the temps in the logbooks. DC-A stated refrigerator temperatures for 2nd floor should have been done but wasn't sure why only 1 entry had been recorded. During observation on 10/25/23 at 12:13 p.m., DC-B recorded food temperatures prior to serving food for 1st floor kitchenette. During interview on 10/25/23 at 12:15 p.m., DC-B stated awareness of the requirement to take temperatures and to record but "forgets in haste at times". DC-B stated it was important to take temperatures to prevent under cooked food from being served. DC-B stated he usually took the refrigerator temperatures for 1st floor AM's but wasn't sure why PM's wasn't done. During observation on 10/25/23 at 12:20p p.m., DC-C recorded food temperatures prior to serving food for 3rd floor kitchenette. During interview on 10/25/23 at 12:18 p.m., DC-C stated she always took the temperatures for the foods, and recorded them. They were to be done before leaving the main kitchen. DC-C stated it was important to temp and record, because "we don't want to get anybody sick". DC-C stated she should have recorded the temperatures for the refrigerator on 3rd floor, and noted the log was missing entries. During interview on 10/25/23 at 1:38 p.m., registered dietician (RD) stated it was important for staff to be utilizing temperature logs and recording the temperatures of foods and refrigerators. RD stated it was an important practice and helped to avoid any food borne illness.	F 812		

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F 812	Continued From page 11 During interview on 10/25/23 at 1:48 p.m., certified dietary manager (CDM) stated he expected staff to check and record food temperatures in the food logbook and on the refrigerator temperature logs. CDM stated it was important to know the food was cooked appropriately and equipment was functioning appropriately. During interview on 10/25/23 at 3:32 p.m., director of nursing (DON) stated she became aware staff had not been recording food and refridgerator temperatures after she had reviewed the logs. DON stated that she had spoken with the CDM about this issue and would expect staff to record temperatures as it could lead to illness or other potential infection issues, if not done. Facility document, titled 1st, 2nd, and 3rd choice temperature log noted for month of October 2023 indicated 5 missing entries for 1st choice meal, 43 missing entries for 2nd choice, and 10 missing temperatures for puree. Kitchenette logs also indicating similar amounts of missing information. Facility document, titled, temperature checks, dated 10/23, indicated that food service staff document hot food temperatures on the appropriate form in temperature books, and initial form.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically	F 851		11/28/23

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F 851	Continued From page 12 submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff.	F 851		

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F 851	Continued From page 13 When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit the payroll-based journal system (PB&J) staffing data to Centers for Medicare and Medicaid Services (CMS). This had the potential to affect all 54 residents residing in the facility. Findings included: The Centers for Medicare and Medicaid Services' (CMS) Payroll Based Journal (PBJ) Staffing Data Report identified during the third quarter of 2023 (4/1/23 - 6/30/23) the facility failed to have registered nurse (RN) coverage and licensed nursing coverage for 24 hours a day for the entire quarter for the following dates: 4/1, 4/2, 4/3, 4/4, 4/5, 4/6, 4/7, 4/8, 4/9, 4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/26, 4/27, 4/28, 4/29, 4/30, 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27,	F 851	An educational in-service has been completed on November 15, 2023 for the business office representatives on the requirement of collecting payroll and consultant hours data to be used to submit payroll-based journal information within the required timeframe. Business office representatives will be educated on the facility policy for payroll based journal and the allotted reporting period. The facility will submit required data as required within the allotted reporting period. The business office representative will provide proof of submission to the facility administrator. Facility administrator will audit the business office for appropriate submission of the payroll based submission and will report the results of the audit to the Quality Assurance Committee.	

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F 851	Continued From page 14 5/28, 5/29. 5/30, 5/31, 6/1, 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, 6/8, 6/9, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, 6/24, 6/25, 6/26, 6/27, 6/28, 6/29, and 6/30. During an interview on 10/25/23 at 10:40 a.m., director of nursing (DON) stated the PBJ report was submitted by the payroll submitter (PS-F). During interview on 10/25/23 at 1:04 p.m., PS-F stated that she was responsible to report the PBJ reports and submits them by exporting the data directly to CMS. PS-F stated the 2023 third quarter data missing in the PBJ was because she had missed the submission window due to a vacation. During interview on 10/25/34 at 1:06 p.m., DON stated that we should be submitting the PBJ data, and we need to have a better plan in place to that if someone PS-F goes on vacation, another person is able to submit the PBJ report. Facility document, titled, Payroll Based Journal (PBJ) Reporting, dated 10/23, indicated the facility will submit direct care staffing information on the schedule specified by CMS, but at a minimum a quarterly basis.	F 851		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 8, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: WHXZ11

Dear Administrator:

The above facility was surveyed on October 23, 2023 through October 26, 2023 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.

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

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

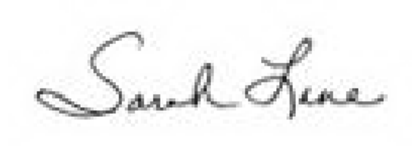
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00634	A. BUILDING: _____ B. WING _____	C 10/26/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/23/23 through 10/26/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was 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 these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H53396540C (MN97087), H53396582C (MN96854), and NO licensing orders were issued. 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. 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.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to have 8 hours of consecutive registered nursing coverage on a daily basis. This	2 810	Corrected.	11/28/23

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	00634	A. BUILDING: _____ B. WING _____	C 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 810	Continued From page 3 had the potential to affect all 54 residents residing in the facility. Findings include: The Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report identified during the third quarter of 2023 (4/1/23 through 6/30/23) the facility failed to have registered nurse (RN) coverage for the entire quarter. The facility provided schedules for the third quarter of 2023 indicated a lack of RN coverage for 8 consecutive hours for the following dates: 4/16, 4/30, 5/7, 5/14, 5/28, 6/3, and 6/11. The facility provided schedules for week of the survey period (10/22/23 through 10/28/23) and month preceding (9/23/23 through10/23/23) indicated a lack of RN coverage for 8 consecutive hours for the following dates: 9/23, 9/24, and 10/1. During an interview on 10/25/23 at 9:40 a.m., staff scheduler (SS-E) stated that when creating the schedule, she made sure to have 24 hours of licensed nursing coverage, and 8 hours of that should be for an RN. SS-A continued that she was not aware that the eight hours of RN coverage meant the RN needed to be in the building. SS-A stated, "I thought the RN could be on call for the eight hour of weekend coverage". During an interview on 10/25/23 at 10:40 p.m., director of nursing (DON) stated there needed to be 8 hours of continuous RN coverage. She was aware of the issue on the weekends with RN coverage.	2 810		

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2 810	Continued From page 4 Facility staff scheduling policy requested, none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff. The DON or designee could perform audits. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 810		

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/25/2023. At the time of this survey, Mother of Mercy Senior Living Building 01 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. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: 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		11/17/2023

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

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

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K 000	Continued From page 2 building and was was determined to be of Type II (111) construction. The facility was surveyed as two facilities. 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. The facility has a capacity of 65 beds and had a census of 54 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility.	K 211	The Means of Egress has been cleared of all equipment that is due to be repaired. The equipment has been and will be placed in the Maintenance Department, not in the egress area. The Maintenance personnel will monitor the hallway daily to ensure no equipment	11/28/23

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K 211	Continued From page 3 Findings include: On 10/25/2023 at 11:51 AM, it was revealed by observation that there was a recliner and a cart with bins stored in the egress corridor near the maintenance 116 room, there were two resident rooms in the corridor. When asked the Director of Environmental Services stated that the recliner was waiting to be repaired. An interview with the Director of Environmental Services and the Maintenance Technician verified this deficient finding at the time of discovery.	K 211	is stored in hallway. Maintenance will audit all egress areas for compliance. This deficiency will be referred to Safety Committee for addition to Safety checks lists that are completed quarterly. The Maintenance Director will be responsible for ongoing monitoring and Safety Committee to review quarterly for compliance	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be	K 222		11/28/23

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K 222	Continued From page 4 electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system	K 222	Stanley Wanderguard has been contracted to fix the delayed egress	

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K 222	Continued From page 5 per NFPA 101 (2012 edition), Life Safety Code section 7.2.1.6.1.1 (3). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/25/2023 at 12:20 PM, it was revealed by observation that the delayed egress door exiting out of Stairwell A on the second-floor east wing did not release when attempting to exit without using the keypad. An interview with the Director of Environmental Services and the Maintenance Technician verified this deficient finding at the time of discovery.	K 222	locking system. This deficiency will be referred to Safety Committee for addition to Safety checks lists that are completed quarterly. The Maintenance Director will be responsible for ongoing monitoring and Safety Committee to review quarterly for compliance	
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5 and 7.2.4.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 226	The penetration in the firewall has been sealed. Any vendors that complete work in the facility will be required to sign a statement regarding life safety in the facilities. Specifically, regarding firewall penetrations. Maintenance will audit firewalls for penetrations.	11/28/23

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K 226	Continued From page 6 On 10/25/2023 at 10:49 AM, it was revealed by observation that there was a penetration in the firewall between assisted living and the care center above the fire doors near the beauty shop 209.4. An interview with the Director of Environmental Services and the Maintenance Technician verified this deficient finding at the time of discovery.	K 226	The facility will institute a plan after a vendor has performed work in the system, maintenance personnel will verify that all penetrations have been sealed. The deficiency will be referred to Safety Committee QAPI plan, where any vendors work is reviewed with Vendor and Verified by Maintenance. The Maintenance Direct will be responsible or ongoing monitoring and Safey Committee to review quarterly for compliance.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		11/28/23

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K 324	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to maintain the kitchen hood and install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 9.2.3, 19.3.2.5.1, 19.3.2.5.3 (9) and 19.3.2.5.4, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.4 and 11.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 10/25/2023 at 12:10 PM, it was revealed by observation that the lock-out switch installed on the residential stoves located in the dining room 306 and in the activities room 161 was not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. 2. On 10/25/2023 between 09:45 AM and 12:45 PM, it was revealed by observation and a review of available documentation that the tag on the kitchen hood stated that the last cleaning was completed on 1/11/2021, and the Director of Environmental Services could not supply documentation showing that it had been completed more recently. An interview with the Director of Environmental Services and the Maintenance Technician verified	K 324	An automatic timers will be installed by the local electrician that will deactivate the residential stoves after 120 minutes at all residential stove locations. Any remodeling of the facility that included adding or moving residential stoves would require 100% compliance with the life safety codes. The automatic timer will be tested annually for compliance. The maintenance Director will be responsible for the ongoing monitoring.	

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K 324	Continued From page 8 these deficient findings at the time of discovery.	K 324		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 10/25/2023 at 10:58 AM, it was revealed by	K 353	1) The ductwork and wires have been lifted off of the sprinkler pipe by the maintenance department. 2) Any vendors that complete work in the facility will be required to sign a statement regarding life safety in the facilities. Specifically regarding Sprinkler Pipes maintenance will audit other areas of facility for compliance The facility will institute a plan after a vendor has performed work in the system, maintenance personnel will verify that the work will be incompliance with life Safety	11/28/23

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K 353	Continued From page 9 observation that there was a section of ductwork resting on the sprinkle pipe and wires attached to the sprinkler pipe located above the ceiling on the opposite side of the smoke barrier doors from resident room 266. 2. On 10/25/2023 at 11:17 AM, it was revealed by observation that there were wires on the sprinkler pipe located above the ceiling near restroom 164. An interview with the Director of Environmental Services and the Maintenance Technician verified these deficient findings at the time of discovery.	K 353	code. The Maintenance Director will be responsible for monitoring for compliance and will be referred to QA committee for monitoring.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		11/28/23

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

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K 363	Continued From page 10 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 10/25/2023 at 11:32 AM, it was revealed by observation that the door to resident room 337 was held open with a small cement block. 2. On 10/25/2023 at 11:45 AM, it was revealed by observation that the door to the Director of Environmental Services office 171 was propped open with a wooden wedge. An interview with the Director of Environmental Services and the Maintenance Technician verified these deficient findings at the time of discovery.	K 363	All door stops have been removed from facility. Personnel will be directed that all door stops are not allowed in the facility. Maintenance will audit all areas of facility to verify compliance. Monitoring for Door Stops will be put on the safety check lists for review during the Safety Committee meeting. This system will automatically refer any identified concerns to the QA committee. The Maintenance Director is responsible for monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2023**

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

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K 372	Continued From page 11	K 372		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 10/25/2023 at 10:55 AM, it was revealed by observation that there were penetrations in the smoke barrier above the smoke barrier doors near resident room 266 caused by ductwork and electrical conduit. 2. On 10/25/2023 at 11:14 AM, it was revealed by observation that there were penetrations in the smoke barrier above the ceiling in the dining room 110.	K 372	Smoke penetrations will be sealed with approved materials. Maintenance will audit other areas of facility for compliance. Any vendors that complete work in the facility will be required to sign a statement regarding life safety in the facilities, specifically regarding Sprinkler Pipes. The facility will institute a plan after a vendor has performed work in the system, maintenance personnel will verify that the work will be incompliance with life Safety code. The Maintenance Director will be responsible or ongoing monitoring and Safey Committee to review quarterly for compliance.	11/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2023**

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

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K 372	Continued From page 12 3. On 10/25/2023 at 11:16 AM, it was revealed by observation that there was a penetration in the smoke barrier above the ceiling near restroom 164 caused by a wire. An interview with the Director of Environmental Services and the Maintenance Technician verified these deficient findings at the time of discovery.	K 372		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 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) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/25/2023 at 10:55 AM, it was revealed by a review of available documentation that the risk assessment that the facility provided at the time of the survey did not include chapters 10 and 11 of NFPA 99 (2012 edition), Health Care Facilities	K 901	Equipment identification stickers have been ordered. All equipment will be tagged and recorded on Chapter 10 and Chapter 11 will be completed for equipment in the facility. Any new equipment that procured will be sent to the maintenance department for inspection, labeled, and added to Facility Risk Assessment. The Maintenance Director will be responsible for ongoing monitoring and will be added to Safety Committee Check list to verify all equipment is labeled.	11/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2023**

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K 901	Continued From page 13 Code. An interview with the Director of Environmental Services and the Maintenance Technician verified this deficient finding at the time of discovery.	K 901		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and	K 920	The power cord has been removed from this room and the equipment plugged directly into the wall. The maintenance department has	11/28/23

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2023**

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K 920	Continued From page 14 10.2.4.2.1, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/25/2023 at 11:34 AM, it was revealed by observation that there was a microwave plugged into a power strip in resident room 337. An interview with the Director of Environmental Services and the Maintenance Technician verified this deficient finding at the time of discovery.	K 920	inspected all other resident areas to verify that no equipment is plugged into a power cord that should be. This deficiency will be referred to Safety Committee for addition to Safety checks lists that are completed quarterly. The Maintenance Director will be responsible for ongoing monitoring and Safety Committee to review quarterly for compliance.	

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	245339	A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____	**10/25/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/25/2023. 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. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: 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		11/17/2023

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

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K 000	Continued From page 1 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	K 000		

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K 000	Continued From page 2 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. 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). The facility has a capacity of 65 beds and had a census of 54 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 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) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a	K 901	Equipment identification stickers have been ordered. All equipment will be	11/28/23

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K 901	Continued From page 3 Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/25/2023 at 10:55 AM, it was revealed by a review of available documentation that the risk assessment that the facility provided at the time of the survey did not include chapters 10 and 11 of NFPA 99 (2012 edition), Health Care Facilities Code. An interview with the Director of Environmental Services and the Maintenance Technician verified this deficient finding at the time of discovery.	K 901	tagged and recorded on Chapter 10 and Chapter 11 will be completed for equipment in the facility. Any new equipment that procured will be sent to the maintenance department for inspection, labeled, and added to Facility Risk Assessment. The Maintenance Director will be responsible for ongoing monitoring and will be added to Safety Committee Check list to verify all equipment is labeled.	