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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: X4Q9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00634

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 07/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 08/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/15/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245339
August 3, 2016

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

Dear Mr. McDevitt:

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

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

Effective July 5, 2016, the above facility is certified for or recommended for:

73 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 3, 2016

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

RE: Project Number S5339025

Dear Mr. McDevitt:

On June 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 25, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2016, effective July 5, 2016 and therefore remedies outlined in our letter to you dated June 20, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245339 (Y1)	A. Building B. Wing (Y2)	7/25/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY CAMPUS OF CARE	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 07/05/2016	ID Prefix F0257 Reg. # 483.15(h)(6) LSC	Correction Completed 07/05/2016	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 07/05/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 08/03/2016	SIGNATURE OF SURVEYOR 10562	DATE 07/25/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/9/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245339	A. Building 01 - MAIN BUILDING 01 B. Wing	7/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY CAMPUS OF CARE	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0021	Correction Completed 06/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 08/03/2016	SIGNATURE OF SURVEYOR 19251	DATE 07/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/9/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245339	A. Building 02 - 3RD FLOOR ADDITION B. Wing	7/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTHER OF MERCY CAMPUS OF CARE	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0021	Correction Completed 06/23/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 08/03/2016	SIGNATURE OF SURVEYOR 19251	DATE 07/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/9/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: X4Q9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00634

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/09/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II — 06/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/13/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2016

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

RE: Project Number S5339025

Dear Mr. McDevitt:

On June 9, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 9, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5339011 that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 19, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 9, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 9, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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 _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was also completed at the time of the standard survey, complaint H5339011, and was unsubstantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		7/5/16

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

Electronically Signed | 06/29/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	06/09/2016

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

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F 156	Continued From page 1 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State	F 156		

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 _____	06/09/2016

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

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F 156	Continued From page 2 ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R85) was provided the required notice of Medicare non-coverage upon termination of the covered Medicare services. Findings include: R85's undated face sheet identified R85 was admitted with a payment source of Medicare Part A, and remained in the facility for 14 days from 1/13/16 through 1/27/16. R85's last covered day of Medicare coverage ended on 1/26/16.	F 156	Facility submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admission or an agreement that a deficiency exists or that the statement of deficiency was correctly cited. It is also not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3 R85's medical record was reviewed, however, no information was identified he had been provided the required notices of Medicare non-coverage prior to his Medicare services ending. During interview on 6/7/16, at 10:30 a.m. social worker (SW)-A acknowledged there was no documented evidence R85 was provided a Notice of Medicare Provider Non-Coverage (CMS-10123) and stated, "We must have lost it." R85 was admitted for an occupational and physical therapy stay at the facility, and should have been given the denial notice two days before his covered services ended. Review of policy titled, "Mother of Mercy procedure for notification for Non-Coverage for Medicare," dated 8/27/15, included, "To comply with Medicare guidelines to notify the Medicare beneficiary and or the responsible party of non-coverage for the Mother of Mercy nursing home." The notice is given directly to the beneficiary or responsible party and a signature to verify the notice along with the date received. The date should occur at least two days prior to the last covered day or the day of admission when it is determined that the individual is non-eligible upon admission.	F 156	a) (SW)-A believes that R85 was provided denial notice two days before his covered services ended, but no signed CMS-10123 form to document it occurred. R85 discharged from facility to home on 1/27/2016. b) This practice has the potential to affect residents who utilize Medicare benefits for skilled rehabilitative service. c)The Director of Social Services or designee will be responsible for issuing the written notice of non-coverage with at least 2 days notice. d) Social Services will maintain a log and monitor that all residents with Medicare services are provided a notice of non-coverage, as required. e) Corrective action will be completed by 7/5/2016.	
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced	F 257		7/5/16

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 _____	06/09/2016

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

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F 257	Continued From page 4 by: Based on observation and interview, the facility failed to ensure comfortable room temperatures were maintained for 7 of 35 residents (R61, R8, R74, R42, R25, R79, R63) who complained about their room and common area dining room temperatures. Findings include: During observation on 6/6/16, at 2:22 p.m. R61 was seated in her wheelchair in her room. R61 was wearing a sweater. During the interview R61 commented about her room temperature and stated, "It is always cold in here." During observation on 6/6/16, at 2:31 p.m. R8 was seated in a wheelchair in her room, next to a card table. R8 was dressed with long-sleeves and a sweater. R8 stated she had concerns about the room, and stated, "The temperature feels too cold." R8 added, "We have to dress accordingly." R8 said she has to put on extra clothes most of the time, and that it was especially cool in the dining room. R8 stated, "Many staff tell me they are cold." R8 said she has told staff about her concerns, "But they don't know what's going on." During observation on 6/6/16, at 6:12 p.m. R74 was in her room and had a sweater on. During interview with the surveyor, when asked what affects her comfort, R74 stated, "Sometimes it's a little cool." During an interview on 6/6/16, at 6:56 p.m. R42 was asked about temperatures in the building and stated, "Today is, well it's ok right now, but mostly it's cool, especially in the dining room."	F 257	a) Thermostat adjusted to maintain temperature range of 71 - 81 degrees during survey. b) It is the goal and practice of facility to provide comfortable and safe temperature level (71 - 81 degrees). Thermostat adjusted as needed during the survey. c) Plan for correction will be for maintenance personnel to regularly check and adjust, as needed the temperature level. Temperature log will be maintained for all units and dining rooms, which will be completed five days per week. d) Environmental Servicers Director or designee will be responsible to maintain the temperature log and comfortable temperature level (71 - 81 degrees). Corrective action will be completed by 7/5/2016.	

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 _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 257	Continued From page 5 During observation on 6/6/2016, at 7:16 p.m. R25 was seated in her room and wearing a sweater. R25 said her room was not always comfortable and stated, "It is very cold in here." During observation on 6/8/16, at 7:58 a.m. in the first floor dining room, there were fifteen residents seated at the tables during the breakfast meal. All 15 residents present were wearing long-sleeved blouses or shirts, and among those, four residents wore knitted sweaters, and one of the four residents was additionally covered in a blanket. Later during breakfast, at 8:12 a.m., R79 complained about the temperature in the dining area and stated, "It feels like fall." In addition, R63 said she also wanted to complain about the room being cold, and stated, "I don't like the weather inside. It's just too cold." During an interview on 6/9/16, at 8:37 a.m. the environmental service technician (EST) stated the goal was to maintain building and room temperatures at, "about 72 degrees." The EST stated, "We try to make people happy." The EST said each floor's temperature was monitored, but said he was not aware if the facility kept a log of room and common area temperatures. The EST also stated he did not daily or routinely check room temperatures. The EST said if there were complaints, "We come into the room or area and make changes." During an environmental tour on 6/9/16, with the EST and universal worker (UW) and in presence of surveyor, the following temperatures were observed:	F 257		

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 _____	06/09/2016

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

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F 257	Continued From page 6 2nd floor at 8:55 a.m.: east wing hall 66 deg. F (degrees Fahrenheit) room #254 67 deg. F room #211 71.5 deg. F 1st floor at 8:58 a.m.: dining room 65 deg. F. north wing 65 deg. F. room #123 66.5 deg. F. 3rd floor at 9:05 a.m.: dining room 71 deg. F. room #354 71 deg. F. west hallway 72 deg. F During an interview at the time of the environmental tour, the EST stated, "It is kinda chilly," as the tour observed the 1st floor hallways and dining area. The EST said he has heard the nursing assistants say it's too hot, "but I'm sure it's not for the residents." In the same interview, the UW stated she too thought it was, "a little cool," and also stated, "maybe we should start a [temperature] log. The UW said the facility always has to look and be mindful of what the residents want, and the focus was always the residents. During an interview on 6/9/16, at 1:14 p.m. the administrator stated the facility tried to keep a temperature range between 72 to 76 degrees. The administrator was not sure and stated, "I'm speculating," specifically how maintenance monitored the building temperatures, but emphasized the staff addresses complaints and tries to accommodate resident needs. The administrator did not know if temperature	F 257		

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 _____	06/09/2016

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

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F 257	Continued From page 7 monitoring logs were kept. The administrator stated, "We know we have a working system," and that the facilty, "Shoots for a range that satisfies a majority of people." A facility policy regarding monitoring of room temperatures was requested, but none was provided.	F 257		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete routine lab work for medication monitoring for 1 of 5 residents (R50) reviewed for unnecessary medication use. Findings include: R50's undated facility face sheet indicated R50 had a diagnosis of hypokalemia (low potassium level) and congestive heart failure. R50's physician orders sheet, dated 4/21/16, indicated R50 took fludrocortisone (a	F 428	a) R50 has received lab test and physician involved with managing potassium levels. b) Review of additional Medication Regimen Review (MRR)forms revealed that other resident MRR's had been addressed. c) Consultant Pharmacist will remove each MRR form from the chart for review. The resident will be checked off as having completed MRR on the resident list only	7/5/16

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 _____	06/09/2016

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

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F 428	Continued From page 8 corticosteroid, which is used to control sodium and fluids in your body) 0.1 mg (milligrams) PO (by mouth) daily. Review of R50's hospital admission records dated 5/15/16, from Centracare Melrose emergency room identified R50 had hypokalemia and was ordered potassium chloride 20 mEq (milliequivalants) daily for 10 days. R50's Medication Administration Record (MAR) identified R50 received 20 mEq of potassium once a day from 5/15/16 through 5/26/16. Review of R50's laboratory report, dated 5/15/16, indicated his last potassium level was 3.2 mMol/L (millimoles per liter) and was considered to be low (normal range 3.5-5 mMol/L). Furthermore, review of laboratory levels indicated on 4/11/16, R50's potassium level was 3.3 mMol/L and on 4/12/16, R50's potassium was 3.0 mMol/L . Review of a document titled, Consultant Pharmacist Drug Review, dated 5/26/16, identified R50 had low potassium and recently completed a 10 day course of potassium supplement. As a result, the consultant pharmacist recommended a re-check of R50's serum potassium level. R50 was identified for being at risk for low potassium because of the oral fludrocortisone he received on a daily basis. During interview on 6/7/16, at 3:29 p.m. registered nurse (RN)-A stated she had not seen the consultant pharmacist's recommendation on 5/26/16, for further follow-up on R50's serum potassium levels. RN-A identified the recommendation was "outside of the window" and would contact R50's primary physician for further	F 428	after MRR form removal, whereas, previous practice was to review MRR form while form was still in the chart. d) Consultant Pharmacist will be responsible for MRR process. Consultant Pharmacist shall double check the MRR forms for identified issues prior to replacing the MRR form back into the chart or MRR forms which have items for follow-up will continue to be given to Director of Nurses or designee. e) Corrective action will be completed by 7/5/2016.	

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F 428	Continued From page 9 follow up on the consultant pharmacist's recommendations for potassium monitoring. A facility policy titled, Documentation and Communication of Consultant Pharmacist Recommendations, dated 11/16/12, identified comments and recommendations concerning drug therapy are communicated in a timely fashion.	F 428		

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 _____	**06/09/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division on June 09, 2016. At the time of this survey, Mother Of Mercy Campus Of Care was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2016

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

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/09/2016**

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two separate buildings. Mother Of Mercy Campus Of Care is a 3 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1983 and was determined to be of Type II(222) construction. In 1999, an addition (Welcome Room) was added to the east that was determined to be of Type V(111) construction. In 2009 the 3rd floor addition was added to the facility above the existing 1983 building and was was determined to be of Type II (111) construction. The 3 buildings have a 2 hour fire separation between the 1983, 1999, and 2009 buildings and additions and the entire facility was downgraded to Type II (111) construction. The building is fully sprinkler protected and the sprinkler system is installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (1999 edition) The facility has	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/09/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The facility has a licensed capacity of 73 and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility had an area open to the corridor with doors on magnetic hold open devices that did not meet the requirements of section 7.2.1.8.2.	K 021	1) Contractor will install smoke detectors in Chapel to correct the deficiency. 2) Contractor (SimplexGrinnell) will have	6/23/16

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 _____	**06/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 021	Continued From page 3 Findings include: On facility tour between the hours of 9:00 AM and 12:00 PM on 6/09/2016, it was observed that the facility's chapel open to the corridor has doors on magnetic hold open devices with no local smoke detectors designed to detect smoke passing through the opening in accordance with 7.2.1.8.2. This deficient practice was verified by the Administrator at time of inspection.	K 021	Chapel project completed by 6/27/2016. Ron Zierden, Environmental Services Director will be responsible for the correction/reoccurrence of this deficiency.	

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 _____	**06/09/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 09, 2016. At the time of this survey, Mother of Mercy Campus of Care 2009 addition 3rd floor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____	**06/09/2016**

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

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two separate buildings. 2009 3rd Floor Addition Mother of Mercy Campus of Care is a 3-story building with no basement. In 2009 the 3rd floor addition was added to the facility above the existing 1983 building and was was determined to be of Type II (111) construction. The building is fully sprinkled protected throughout. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 73 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING **02 - 3RD FLOOR ADDITION** B. WING _____	**06/09/2016**

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K 000	Continued From page 2 NOT MET:	K 000		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility had an area open to the corridor with doors on magnetic hold open devices that did not meet the requirements of section 7.2.1.8.2. Findings include: On facility tour between the hours of 9:00 AM and 12:00 PM on 6/09/2016, it was observed that the facility's chapel open to the corridor has doors on magnetic hold open devices with no local smoke detectors designed to detect smoke passing	K 021	1) Contractor will install smoke detectors in the Chapel to correct this deficiency. 2) Contractor (SimplexGrinnell) will complete the Chapel project by 6/27/2016. 3) Ron Zierden, Environmental Services Director will be responsible for the correction/reoccurrence of this deficiency.	6/23/16

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 _____	**06/09/2016**

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K 021	Continued From page 3 through the opening in accordance with 7.2.1.8.2. This deficient practice was verified by the Administrator at time of inspection.	K 021		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
June 20, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5339025

Dear Mr. McDevitt:

The above facility was surveyed on June 6, 2016 through June 9, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5339011 that was found to be unsubstantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Pam Kerssen, RN, APM, (218) 308-2129.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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 _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 6-9, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. A complaint investigation was also completed at the time of the standard survey, complaint H5339011, and was unsubstantiated. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 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 ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (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. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		7/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 302	Continued From page 3 by: Based on interview and document review, the facility failed to ensure residents and interested parties were provided information regarding the Alzheimer's dementia training provided to staff, who received the training, how often staff were trained, and a description of the training provided. This had the potential to affect all current and future residents of the facility and their families. Findings include: A review of employees' records on 6/8/16, at 12:53 p.m. indicated the facility utilized various courses to meet Alzheimer's dementia training requirements. A multi-module dementia series entitled "Hand in Hand," was required for new employees, and computer-based "EduCare" and "Health Care Academy" dementia courses were required annually for all employees thereafter. Coursework descriptions identified learning objectives which included a description of dementia symptoms, strategies for communicating, understanding behaviors, and identifying ways to prepare for and respond to actions and reactions in persons with dementia. A sample of employee transcripts was reviewed which indicated the facility provided training to all staff who worked on the dementia unit in the facility. However, there was no indication this information (a description of the dementia training, which employees received training, and the frequency of the training) was fully provided to prospective or current residents and family, in any form, either written or otherwise. During an interview on 6/9/16, at 10:12 a.m. social worker (SW)-B stated she does not tell new admissions specifically about what dementia training staff receive. SW-B stated, "We do have	2 302	Corrected.	

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 _____	06/09/2016

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2 302	Continued From page 4 trained staff," and they "are trained yearly, if not more." SW-B acknowledged that the details of the dementia training, who was trained, and how often was "not communicated," on the facility's website, or as part of the admission packet. The SW-B said, "I suppose it needs to be beefed up more." During an interview on 6/9/16 at 1:22 p.m., the administrator stated he felt the facility provided information "that addresses and serves the nature of that requirement." The administrator said, "I feel we do identify," that staff are trained. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its process to ensure: Alzheimer's training is timely completed by facility staff; and residents and other interested parties are made aware, either in written or electronic form, what training is provided to staff, which staff received training, the frequency of training, and a description of the training topics. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 302		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (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	21426		7/11/16

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 _____	06/09/2016

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21426	Continued From page 5 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. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete an initial tuberculosis (TB) symptom screen upon hire for 1 of 6 employees (NA-A) reviewed for compliance. In addition, the facility failed to appropriately administer a second step tuberculin skin test (TST) for 1 of 5 residents (R40) reviewed for compliance for TB screening. Findings include: TB SCREENINGS: Nursing assistant (NA)-A was hired 2/22/16, and received an Interferon-Gamma Release Assay (IGRA) (a whole-blood test used to diagnose TB infection) which indicated NA-A had a negative TB result on 8/19/15, however, NA-A's personnel file lacked evidence a TB symptom screen was completed. During an interview on 6/9/16, at 8:21 a.m. the director of nursing (DON) acknowledged she did not know where the TB symptom screen for NA-A	21426	Correction will be completed by 7/11/2016.	

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	00634	A. BUILDING: _____ B. WING _____	06/09/2016

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MOTHER OF MERCY CAMPUS OF CARE	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

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21426	Continued From page 6 was located. An undated policy titled, Tuberculosis Screening-Employees, identifies there are two components of serial TB screening which includes TB testing for the presence of infection, either with a TST and TB blood test and assessing for current symptoms of active TB disease. RESIDENT SKIN TESTS: R40's medical record, dated 9/21/15, indicated she had received a first step TST with a negative result, however, results of the second step TST dated 10/5/15, was charted as "not given." During an interview on 6/9/16, at 8:21 a.m. the DON verified the facility did not give R40 a second step TST and stated, "I honestly cannot tell you why it happened," and should have been tracked and followed up on accordingly. An undated policy titled, Tuberculosis Screening - Residents, identifies if the first step TB test is non-reactive, the second test will be administered one to three weeks later and documented in the resident's chart. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding current tuberculosis regulations for health care facilities and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		

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21530	Continued From page 7	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		7/11/16

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21530	Continued From page 8 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete routine lab work for medication monitoring for 1 of 5 residents (R50) reviewed for unnecessary medication use. Findings include: R50's undated facility face sheet indicated R50 had a diagnosis of hypokalemia (low potassium level) and congestive heart failure. R50's physician orders sheet, dated 4/21/16, indicated R50 took fludrocortisone (a corticosteroid, which is used to control sodium and fluids in your body) 0.1 mg (milligrams) PO (by mouth) daily. Review of R50's hospital admission records dated 5/15/16, from Centracare Melrose emergency room identified R50 had hypokalemia and was ordered potassium chloride 20 mEq (milliequivalants) daily for 10 days. R50's Medication Administration Record (MAR) identified R50 received 20 mEq of potassium once a day from 5/15/16 through 5/26/16. Review of R50's laboratory report, dated 5/15/16, indicated his last potassium level was 3.2 mMol/L (millimoles per liter) and was considered to be low (normal range 3.5-5 mMol/L). Furthermore, review of laboratory levels indicated on 4/11/16, R50's potassium level was 3.3 mMol/L and on 4/12/16, R50's potassium was 3.0 mMol/L .	21530	Corrected.	

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21530	Continued From page 9 Review of a document titled, Consultant Pharmacist Drug Review, dated 5/26/16, identified R50 had low potassium and recently completed a 10 day course of potassium supplement. As a result, the consultant pharmacist recommended a re-check of R50's serum potassium level. R50 was identified for being at risk for low potassium because of the oral fludrocortisone he received on a daily basis. During interview on 6/7/16, at 3:29 p.m. registered nurse (RN)-A stated she had not seen the consultant pharmacist's recommendation on 5/26/16, for further follow-up on R50's serum potassium levels. RN-A identified the recommendation was "outside of the window" and would contact R50's primary physician for further follow up on the consultant pharmacist's recommendations for potassium monitoring. A facility policy titled, Documentation and Communication of Consultant Pharmacist Recommendations, dated 11/16/12, identified comments and recommendations concerning drug therapy are communicated in a timely fashion. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for effective communication when consulting pharmacist's recommendations are made. Audits could be completed to ensure compliance with follow through of recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

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21705	Continued From page 10	21705		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure comfortable room temperatures were maintained for 7 of 35 residents (R61, R8, R74, R42, R25, R79, R63) who complained about their room and common area dining room temperatures. Findings include: During observation on 6/6/16, at 2:22 p.m. R61 was seated in her wheelchair in her room. R61 was wearing a sweater. During the interview R61 commented about her room temperature and stated, "It is always cold in here." During observation on 6/6/16, at 2:31 p.m. R8	21705	Corrected.	7/11/16

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21705	Continued From page 11	21705		

was seated in a wheelchair in her room, next to a card table. R8 was dressed with long-sleeves and a sweater. R8 stated she had concerns about the room, and stated, "The temperature feels too cold." R8 added, "We have to dress accordingly." R8 said she has to put on extra clothes most of the time, and that it was especially cool in the dining room. R8 stated, "Many staff tell me they are cold." R8 said she has told staff about her concerns, "But they don't know what's going on."

During observation on 6/6/16, at 6:12 p.m. R74 was in her room and had a sweater on. During interview with the surveyor, when asked what affects her comfort, R74 stated, "Sometimes it's a little cool."

During an interview on 6/6/16, at 6:56 p.m. R42 was asked about temperatures in the building and stated, "Today is, well it's ok right now, but mostly it's cool, especially in the dining room."

During observation on 6/6/2016, at 7:16 p.m. R25 was seated in her room and wearing a sweater. R25 said her room was not always comfortable and stated, "It is very cold in here."

During observation on 6/8/16, at 7:58 a.m. in the first floor dining room, there were fifteen residents seated at the tables during the breakfast meal. All 15 residents present were wearing long-sleeved blouses or shirts, and among those, four residents wore knitted sweaters, and one of the four residents was additionally covered in a blanket.

Later during breakfast, at 8:12 a.m., R79 complained about the temperature in the dining area and stated, "It feels like fall." In addition,

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R63 said she also wanted to complain about the room being cold, and stated, "I don't like the weather inside. It's just too cold."

During an interview on 6/9/16, at 8:37 a.m. the environmental service technician (EST) stated the goal was to maintain building and room temperatures at, "about 72 degrees." The EST stated, "We try to make people happy." The EST said each floor's temperature was monitored, but said he was not aware if the facility kept a log of room and common area temperatures. The EST also stated he did not daily or routinely check room temperatures. The EST said if there were complaints, "We come into the room or area and make changes."

During an environmental tour on 6/9/16, with the EST and universal worker (UW) and in presence of surveyor, the following temperatures were observed:

2nd floor at 8:55 a.m.:
east wing hall 66 deg. F (degrees Fahrenheit)
room #254 67 deg. F
room #211 71.5 deg. F

1st floor at 8:58 a.m.:
dining room 65 deg. F.
north wing 65 deg. F.
room #123 66.5 deg. F.

3rd floor at 9:05 a.m.:
dining room 71 deg. F.
room #354 71 deg. F.
west hallway 72 deg. F

During an interview at the time of the

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21705	Continued From page 13 environmental tour, the EST stated, "It is kinda chilly," as the tour observed the 1st floor hallways and dining area. The EST said he has heard the nursing assistants say it's too hot, "but I'm sure it's not for the residents." In the same interview, the UW stated she too thought it was, "a little cool," and also stated, "maybe we should start a [temperature] log. The UW said the facility always has to look and be mindful of what the residents want, and the focus was always the residents. During an interview on 6/9/16, at 1:14 p.m. the administrator stated the facility tried to keep a temperature range between 72 to 76 degrees. The administrator was not sure and stated, "I'm speculating," specifically how maintenance monitored the building temperatures, but emphasized the staff addresses complaints and tries to accommodate resident needs. The administrator did not know if temperature monitoring logs were kept. The administrator stated, "We know we have a working system," and that the facilty, "Shoots for a range that satisfies a majority of people." A facility policy regarding monitoring of room temperatures was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop and implement policies and procedures to ensure resident rooms and common areas are maintained at a comfortable temperature and educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality committee for review.	21705		

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21705	Continued From page 14 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21705		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This had the potential to affect all 67 residents and their families who resided in the facility. Findings include: On 6/7/16, at 10:00 a.m., social worker (SW)-A verified there was currently not an active family council at the facility. SW-A added that the facility provided information in the admission packet to newly admitted residents, however, there have been no formal attempts to form a family council with families of residents that had lived at the facility prior to this process. SW-A stated they had	21942	Corrected.	7/11/16

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21942	Continued From page 15 not attempted to contact the families of residents currently living at the facility about organizing a family council group, but stated, "That would be a good idea." SW-A provided a sheet of paper that is posted in the facility, encouraging family members to come forward with concerns, but it did not specifically invite family members to join a family council group or attend an organized family council meeting. On 6/7/16, at 10:10 a.m., SW-B stated she had no information regarding any previous attempts of forming a family council and stated, "We haven't really done anything with that in the last year or two." On 6/9/16, at 9:36 a.m., family member (FM)-A stated her family member had been a resident at the facility for several years and she had never received any information or been approached about an attempt to form a family council. The facility was unable to provide a policy and procedure regarding family council. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a Family Council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		