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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZGUF

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 **09/21/2015** (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 **76** (L18)

13.Total Certified Beds **76** (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
	76			
(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 :
Jessica Sellner, Unit Supervisor 09/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/24/2015 (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 10/12/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 24, 2015

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

RE: Project Number S5339024

Dear Mr. McDevitt:

On August 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 7, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 8, 2015 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 August 7, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 11, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 7, 2015, effective September 11, 2015 and therefore remedies outlined in our letter to you dated August 21, 2015, 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
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245339
September 24, 2015

Mr. Dean McDevitt, Administrator
Mother of Mercy Campus of Care
230 Church Avenue, Box 676
Albany, Minnesota 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 September 11, 2015 the above facility is certified for or recommended for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245339	A. Building B. Wing	9/21/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **08/31/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **09/03/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/03/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/04/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/03/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/03/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/04/2015**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **08/31/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/03/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/03/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/11/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	09/24/2015	29249	09/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/7/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245339	A. Building B. Wing 01 - MAIN BUILDING 01	9/8/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0067	09/04/2015	ID Prefix Reg. # NFPA 101 LSC K0144	09/04/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GS/KJ	Date: 09/24/2015	Signature of Surveyor: 34764	Date: 09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/4/2015		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245339	A. Building B. Wing 02 - 3RD FLOOR ADDITION	9/8/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0067	09/04/2015	ID Prefix Reg. # NFPA 101 LSC K0144	09/04/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GS/KJ	**Date:** 09/24/2015	**Signature of Surveyor:** 34764	**Date:** 09/08/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/4/2015		**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: ZGUF

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 **08/07/2015** (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 **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 09/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/14/2015 (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 09/29/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 21, 2015

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

RE: Project Number S5339024

Dear Mr. McDevitt:

On August 7, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<u>Informal Dispute Resolution</u> - 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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

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 September 16, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 16, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 November 7, 2015 (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 February 7, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
gary.schroeder@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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 _____	08/07/2015

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.	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 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	F 156		8/31/15

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

Electronically Signed | 08/31/2015

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

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F 156	Continued From page 1	F 156		

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 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

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F 156	Continued From page 2 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 provide the required notice of Medicare non-coverage in a timely manner for 1 of 3 residents (R35) reviewed for liability notices. Findings include: R35's admission Minimum Data Set (MDS) dated 3/12/15, indicated R35 was admitted to the facility with skilled coverage beginning 3/5/15. R35 received a Notice of Medicare Non-Coverage dated 3/12/15, which indicated R35's skilled rehabilitation services were to end on 3/13/15. R35 had met therapy goals and was to be discharged to an assisted living (AL) apartment. R35's signature was obtained to reflect the notification was received and understood, with a signature date of 3/12/15. R35 received the discharge notice one day before services ended, and not two days as required by	F 156	The 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. 1) R35 received a 2 day verbal notice of Medicare non-coverage from LSW-A on 3/11/15. This was followed by a written notice of Medicare non-coverage on	

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F 156	Continued From page 3 Medicare. During interview on 8/7/15, at 10:16 a.m. licensed social worker (LSW)-A stated R35 had completed his Medicare Part A stay and would be discharged to his apartment. She stated she was aware a two day notice must be given for Medicare non-coverage, however, she did not get the liability notice signed by R35 on time. A facility policy titled MOTHER OF MERCY PROCEDURE FOR NOTIFICATION OF NONCOVERAGE FOR MEDICARE , undated, indicated "The appropriate denial letter is initiated: On or before the last covered day when Medicare skilled level of care is no longer needed." The policy did not indicate the Notice of Medicare Non-Coverage was to be issued and signed by the resident/resident representative no later than two days prior to coverage ending as required by Medicare.	F 156	3/12/15. The verbal notice was not documented. R35 was discharged from the facility to an AL apt on 3/13/15. 2) This practice has the potential to affect any residents who utilize Medicare benefits for skilled rehabilitation services. 3) The facility procedure for "Notification of Non-Coverage for Medicare" has been reviewed and updated (attached). The policy now includes a 2 day minimum notice requirement for issuance of a written "Notice of Medicare Non-Coverage." The 2 day requirement was not in the previous policy. The facility has 2 licensed social workers that are responsible for issuing the written notices of non-coverage. Both social workers have reviewed the updated policy, which includes the 2 day notice requirement and will follow stated policy. 4) DON will audit at least 2 resident charts per month for 4 months. Residents will be selected from those who have been discharged from Medicare covered services within the previous 30 days.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176		9/3/15

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F 176	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess ability to self administer medications for 1 of 1 residents (R1) observed who received inhaled medication, and 1 of 6 residents (R17) observed who received oral medications. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/12/15, indicated the resident had cognitive impairment related to a traumatic brain injury (TBI), and required extensive assist for all activities of daily living (ADL). R1's Physician Orders dated 8/6/15, indicated an order for sodium chloride, solution for nebulization, 3%, give 4 milliliters (ml) by inhalation two times daily. There was no order which indicated R1 had been assessed to to self administer the nebulizer treatment. During observation on 8/3/15, at 6:05 p.m. R1 was lying in bed and Licensed practical nurse (LPN)-B administered medications via the gastrostomy tube (inserted through the abdomen and delivers nutrition and medications directly into the stomach). LPN-B then initiated the nebulizer treatment, attached it to the tracheostomy, and exited the room. During interview on 8/3/15, at 6:05 p.m. LPN-B stated she does not stay in the room with R1 when receiving the nebulizer treatment, however, she was not aware if the resident had an assessment completed to self administer medications.	F 176	1) An assessment for self-administration of medications has been completed for R1. Due to R1's cognitive status and persistent vegetative state, he is not able to remove his nebulizer treatment, once in place by nursing, and self-administration of nebulizer treatment after set-up is appropriate for this resident. MD order has been obtained for same the R1's care plan has been updated to reflect same. It is the expectation at Mother of Mercy that staff will follow facility policies as well as each resident's plan of care. Staff will follow Medication Administration policy for R17, as they would for all other residents. Nursing staff will maintain direct supervision of R17 until her medication is consumed in its entirety. 2) All residents receiving medications have the potential to be affected. 3) Facility's "Medication Administration" policy was reviewed at Mandatory Nursing Dept Mtgs held on 8/12 & 8/13. All licensed nurses and TMA's have been provided with a copy of the facility's "Medication Administration" policy, for immediate review (8/27/15) with a message from DON regarding specific survey findings/areas for correction. In addition, another mandatory Nurse/TMA meeting will be held on 9/3/15, during which DON or designee will provide further review of the "Medication Administration" policy as well as the	

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F 176	Continued From page 5 During another observation on 8/6/15, at approximately 8:00 a.m. LPN-C exited R1's room and the nebulizer treatment was observed attached to R1's tracheostomy. During interview on 8/6/15, at 3:04 p.m. registered nurse (RN)-C stated no self administration assessment was completed for R1, and stated R1 should not be self administering nebulizer treatments without an assessment. R17's quarterly MDS dated 6/2/15, indicated the resident had no cognitive impairment. During observation on 8/5/15, at 12:15 p.m.. RN-A entered the dining room where R17 was eating lunch and asked R17 if she could put the residents Miralax (a laxative), into one of the cups of fluid she had on her tray. RN-A put the Miralax into R17's sippy cup which had water in it, and replaced the lid on the cup. There were two other residents at the table with R17 who were also waiting for their lunch, and RN-A walked away leaving R17 with the cup of Miralax. On 8/5/15 at 12:37 p.m., RN-A, left the dining room to go on break, and RN-A did not check on R17 to see if she had drank the Miralax. During observation, R17 had a small amount of water left in the bottom of the sippy cup containing the water and Miralax. During interview on 8/6/15, at 9:24 a.m.. RN-B stated R17 had not been assessed to self administer medications, and the Miralax should not be left in R17's cup for her to take on her own. RN-B stated when she administers R17's Miralax, she puts it in the residents water, and she drinks the entire glass when she is standing with her.	F 176	facility policy re: "Self-Administration of Medications." Residents who have been deemed appropriate for self-administration of medications based on an assessment &/or per facility policy, and for whom the facility has obtained an order for self-administration, will be allowed to do so. 4) Each RN Unit Mgr will review each of their respective residents' Plans of Care to ensure the appropriate assessments and/or orders are in place for any residents who wish to self-administer medications. RN Unit Mgrs will re-evaluate residents who do self-administer medications on a quarterly basis, in conjunction with the residents' care conferences, or as appropriate with resident changes, to determine whether self-administration continues to be appropriate.	

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F 176	Continued From page 6 During interview on 8/6/15, at 10:53 a.m.. RN-C, (the RN taking the place of the director of nursing (DON) in her absence), stated if R17 did not have an assessment to self administer medication, it would not be appropriate to put Miralax in a resident's water cup and leave the resident without monitoring. RN-C stated a self administration of medication assessment is not completed on every resident, and is only completed if requested by the resident. The Facility policy titled Medication Administration dated 12/10/12, noted any medications or ointments left at the bedside must be ordered as such by the physician. Each resident must have a self-administration observation (LPN) and assessment (RN) completed prior to the medications being left at the bedside for the resident to self-administer.	F 176		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's care plan for 3 of 8 residents (R75, R1, and R2), who were observed during personal cares. Findings include: R75's significant change Minimum Data Set	F 282	1) A message was sent by DON to all nursing department staff for immediate review. It is the expectation within the nursing dept that all staff will follow the residents' RIS (Resident Information Sheet)/Plan of Care. Charge Nurses have been instructed to observe/monitor for compliance and to address noncompliance with staff members	9/3/15

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F 282	Continued From page 7 (MDS) dated 6/29/15, indicated the resident had severe cognitive impairment, required extensive assistance of one staff with bed mobility, transfers, locomotion on the unit, eating, toilet use, personal hygiene, was totally dependent on staff for dressing, and was occasionally incontinent of urine and frequently incontinent of bowel. R75's care plan dated 6/29/15, included R75 required assistance of 1-2 staff and an EZ stand for transfers, and staff were directed to apply a sling to her left arm for support while transferring, which could then be removed after the transfer was complete, and staff was to, "Refer to therapy prn [as needed], follow therapy recommendations as they occur." During observation on 8/5/15, at 7:30 a.m., licensed practical nurse (LPN)-D and LPN-E transferred R75 from the wheelchair to a commode in the resident's room with the EZ stand, and then transferred her back to the wheelchair. R75's left arm hung flaccid by the side of her body, and she was not wearing the sling on the left arm for support during either transfer as directed by the care plan. During observation on 8/6/15, at 9:25 a.m. nursing assistant (NA)-J transferred R75 in the EZ stand from the wheelchair to the toilet, and then from the toilet to the recliner. R75's left arm hung flaccid by her side, and R75 was not wearing a sling on the left arm for support during either transfer as directed by the care plan. During interview on 8/7/15, at 1:05 p.m., RN-E stated staff should be applying the left arm splint for support to R75's arm during transfers as	F 282	immediately. 2) All residents receiving care within the facility have the potential to be affected. 3) All nursing dept staff will be provided with additional education at mandatory meeting to be held on 9/3/15. Topics to be covered will include but not be limited to: the routine use of the RIS (Resident Information Sheet) and the importance of following the resident's Plan of Care. 4) RN Unit Mgrs will observe for compliance with Plan of Care during any/all interactions with residents throughout their normal work hours and follow up immediately if concerns are noted. Formal audits of compliance will occur on each Unit at least every 2 weeks x 6 weeks, and monthly thereafter. DON will designate and maintain audits.	

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directed by the residents care plan.

During interview on 8/7/15, at 1:21 p.m. physical therapy assistant (PTA)-A stated the left arm sling was recommended to be used during all transfers for R75 to support her left arm and decrease swelling during transfers.

R1's quarterly MDS dated 6/12/15, indicated the resident had severe cognitive impairment related to a traumatic brain injury (TBI), and required extensive assist for all activities of daily living (ADL).

R1's care plan dated 6/30/15, instructed staff to use an EZ lift (a mechanical lift) for all transfers, and R1 should have bilateral protectors to feet with transfers to prevent bumping/bruising. The care plan indicated R1 was at risk for bruising related to spasms and mechanical lift with transfers, and staff were instructed to use care when transferring the resident using hoyer lift. The care plan also directed R1's bilateral siderails were to be padded to prevent injury with turning and repositioning.

During observation on 8/4/15, at 2:42 p.m. R1 was lying in bed and only the right side rail was padded.

During observation on 8/5/15, at 7:13 a.m. R1 was lying in bed and only the right side rail was padded.

During observation on 8/5/15, at 8:12 a.m. NA-N assisted nursing student (NS)-A and NS-B to transfer R1 from bed to the wheelchair with the EZ lift hoyer. No protectors were applied to R1's feet during the transfer as directed by the care

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plan.

During observation on 8/5/15, at 11:11 a.m. R1 was lying in bed and padding was noted on the right side rail only.

During observation on 8/6/15, at 8:52 a.m. NA-O and NA-N transferred R1 from bed to the wheelchair using the EZ lift, and no protectors were applied to his feet during the transfer.

During interview on 8/6/15, at 9:48 a.m. NA-N stated she was not aware of any boots or protection R1 should have on his feet during transfers, nor was she aware why only the right siderail was padded, but not the left.

During interview on 8/6/15, at 10:12 a.m. RN-C stated R1 is to wear foot protectors during all transfers, and both side rails should be padded according to the residents care plan.

R2s quarterly MDS dated 6/17/15, indicated the resident had severe cognitive impairment, had limited mobility, and required extensive assistance with all ADL's.

R2's Care plan dated 7/7/15, instructed staff to reposition the resident every two hours, indicated the resident needed total assist of two staff and a hoyer lift for all transfers, and staff was to apply dermasavers (sleeve protectors) on both upper extremities (arms) to protect skin and to update the nurse, physician, or dietary with any concerns.

Continuous observation of R2 was completed on 8/5/15, from 12:02 p.m. to 2:18 p.m.

-At 12:02 p.m. R2 was seated in her wheelchair in

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F 282	Continued From page 10 the dining room table waiting for lunch to be served, R2 did not have the sleeve protectors on at that time. -At 12:47 p.m. R2 was sitting in her wheelchair next to the nurse's station leaning to the right in her wheelchair with her right arm leaning on the wheelchair arm rest. R2 did not have the sleeve protectors on. -At 12:56 p.m. RN- D went to R2's room and got the sleeve protectors and put them on the resident. During interview on 8/6/15, at 9:13 a.m. NA-E stated R2 was to have the sleeve protectors on at all times because she bruises easily and they protect her arms from injury. During interview on 8/6/15, at 9:19 a.m. RN-B stated R2 should wear the sleeve protectors at all times when out of bed because the resident had seizures and bruised easily, so they protect her arms from injury. During interview on 8/6/15, at 1:25 p.m. NA-D stated R2 will often grab onto her own arms causing bruising to her arms so staff is instructed to ensure the resident had her sleeve protectors on.	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		9/4/15

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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 309	Continued From page 11 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure timely care was provided for 1 of 1 resident who was unable to communicate their needs, (R75) who fell when attempting to self transfer to the toilet after a suppository. Also, the facility failed to ensure 1 of 3 residents observed who was at risk of bruising and injury with transfers, (R1), had interventions in place to prevent injury as assessed. In addition, the facility failed to monitor bruising and skin conditions for 2 of 4 residents (R16 and R19) who was observed to have bruising. Findings include: R75's significant change Minimum Data Set (MDS) dated 6/29/15, indicated the resident had severe cognitive impairment, required extensive assistance with all activities of daily living (ADL's), was occasionally incontinent of urine, and frequently incontinent of bowel. R75's Care Plan dated 6/29/15, indicated R75 was at high risk for falls with interventions including staff to address ADL needs in a timely manner and anticipate resident needs as they are not made apparent. The care plan also directed staff R75 required assistance of 1-2 staff and an EZ stand for transfers, was frequently incontinent of bowel and occasionally incontinent of bladder, and had difficulty making herself understood at times related to a stroke.	F 309	1) All nursing dept staff received notification from DON for immediate review regarding the affected residents (R75, R1, R16 R19) and need for immediate correction (8/27/15). It is the expectation within the nursing dept that all staff will follow the resident's RIS (Resident Information Sheet)/Plan of Care. Charge Nurses have been instructed to observe/monitor for compliance and to address noncompliance with staff members immediately. RN Unit Mgr provided reminders and education to nursing staff on the unit regarding timely follow up of PRN's for R75 and for all residents. Open area on R16's forehead is currently being monitored weekly and as needed until healed. R16 has an area on her forehead where physician has previously indicated she had a probable basal cell carcinoma. The area had been deroofed and physician also indicated the area would probably slowly continue to grow back. Resident's care plan has been updated to reflect this diagnosis. R16 will be observed on bath day for skin changes, which will be reported to a nurse for further evaluation. Resident/family have indicated they wish no further	

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F 309	Continued From page 12 R75's physician orders for August 2015, included, "Dulcolax Laxative suppository 10 milligrams (mg) rectally once a day as needed for constipation." A review of the manufacturer's package insert for Dulcolax 10 mg suppositories indicated, "This product generally produces bowel movement in 15 minutes to 1 hour." During observation on 8/5/15, at 8:06 a.m., R75 was sitting in the wheelchair at the dining room table drinking from a straw while holding a cup independently in her right hand. R75's left arm was resting on the arm rest on the wheelchair, and had a large gauze dressing from her wrist to her elbow. During interview on 8/5/15, at 8:11 a.m. licensed practical nurse (LPN)-E stated R75 had a fall earlier that morning and sustained a large skin tear, measuring 9.5 centimeters (cm) by 3.7 cm, on the upper left forearm. LPN-E stated she gave R75 a suppository at 5:45 a.m. and R75 had self transferred later that morning because she had to go to the bathroom about 7:15 a.m. and fell. LPN-E stated she had worked the night shift and reported to staff she had given R75 a suppository at approximately 5:45 a.m. LPN-E stated when staff responded to R75's chair alarm, the resident told staff she needed to go to the bathroom. LPN-E stated she was not sure what the protocol was for day staff to monitor someone who had received a suppository to ensure they were toileted timely. During interview on 8/6/15, at 9:40 a.m., LPN-D stated she was on a different floor of the facility	F 309	intervention related to R16 probably carcinoma. Bruises observed on R19 were assessed, measured, and documented for monitoring on 8/5/15 by RN-C during the time of survey. Care plan has been updated related to resident being at high risk for bruising. 2) All residents receiving care within the facility have the potential to be affected. 3) All nursing dept staff will be provided with additional education at mandatory meeting to be held on 9/3/15. Topics to be covered will include but not be limited to: the routine use of the RIS (Resident Information Sheet) and the expectation/importance of following the resident's Plan of Care, the need for timely checks for residents who are unable to communicate their needs, as well as the need to report any new bruises or changing skin concerns immediately to a nurse for evaluation. Nurses will review facility "Standing Orders for Wounds and Skin Care Protocols" at meeting on 9/3/15. eMAR has been configured so that when a PRN medication is administered, a task auto-populates 30 minutes later, to alert the nurse to follow up on the effectiveness of the PRN medication if not already done. 4) RN Unit Mgrs will observe for compliance with Plan of Care during	

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F 309	Continued From page 13 when R75 fell on 8/5/15, and when she returned, staff were tending to R75. LPN-D stated R75 wanted to go to the toilet because she had a suppository earlier that morning, and staff is, "Trying to get better when someone has had a suppository," to ensure they are monitored closely to assist them to the bathroom timely. LPN-D stated it was reported during shift change that R75 had a suppository, and staff should have checked with R75 at least within the hour from having the suppository to see if she had to go to the bathroom to prevent the resident from attempting self transferring and falling. R1's quarterly MDS dated 6/12/15, indicated the resident had severe cognitive impairment related to a traumatic brain injury (TBI), and required extensive assist for all activities of daily living (ADL). R1's care plan dated 6/30/15, instructed staff to use an EZ lift (a mechanical lift) for all transfers, and R1 should have bilateral protectors to feet with transfers to prevent bumping/bruising, and injury to feet. The care plan indicated R1 was at risk for bruising related to spasms and mechanical lift with transfers, and staff were instructed to use care when transferring the resident using hoyer lift. The care plan also directed R1's bilateral siderails were to be padded to prevent injury with turning and repositioning. During observation on 8/4/15, at 2:42 p.m. R1 was lying in bed and only the right side rail was padded. During observation on 8/5/15, at 7:13 a.m. R1	F 309	any/all interactions with residents and follow up immediately if concerns are noted. Formal audits of compliance will occur on each Unit at least every 2 weeks x 6 weeks, and monthly thereafter. DON will designate and maintain audits. RN Unit Mgrs or designee will perform a random audit on 2 baths per week x 4 weeks, then 2 baths monthly thereafter to ensure any skin concerns are noted and appropriate follow up has taken place. RN Unit Mgrs will also provide on the spot education to any staff that did not note or report such skin concerns. Any noted patterns or trends will be reported to the QA committee for further recommendation.	

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was lying in bed and only the right side rail was padded.

During observation on 8/5/15, at 8:12 a.m. NA-N assisted nursing student (NS)-A and NS-B to transfer R1 from bed to the wheelchair with the EZ lift hoyer. No protectors were applied to R1's feet during the transfer to protect the residents feet from injury.

During observation on 8/5/15, at 11:11 a.m. R1 was lying in bed and padding was noted on the right side rail only.

During observation on 8/6/15, at 8:52 a.m. NA-O and NA-N transferred R1 from the bed to the wheelchair using the EZ lift, and no protectors were applied to his feet during the transfer to protect the residents feet from bruising and injury.

During interview on 8/6/15, at 9:48 a.m. NA-N stated she was not aware R1 was to have any protection on his feet during transfers, nor did she know why only the right siderail was padded, but not the left.

During interview on 8/6/15, at 10:12 a.m. RN-C stated R1 was to wear foot protectors during all transfers, and both side rails should be padded to prevent injury to R1.

R16's quarterly MDS dated 5/13/15, noted no concerns related to skin conditions.

During observation on 8/3/15, at 3:17 p.m. R16 had an obvious, abrasion like area, on her forehead. This abrasion area on R16's forehead was noted throughout the entire survey from

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F 309	Continued From page 15 8/3/15 - 8/7/15. R16's Physician progress notes dated 9/4/14, noted the resident had probable basal cell cancer on her forehead, which had been 'deroofed' (removed) and the area on her forehead had improved, however, the area would probably slowly continue to grow back. R16's medical record was reviewed and there was no documentation or assessment regarding the area on R16's forehead which identified staff was monitoring the area for any changes. Comprehensive skin assessment note dated 8/13/14, noted R16 "does currently have a lesion on her forehead which has been examined by the MD and presumed to be a cancerous lesion. Resident and family do not wish further interventions for this at the current time." During interview on 8/4/15, at 4:01 p.m. RN-C stated no skin issues were being monitored for R16 by staff at this time. During interview on 8/4/15, at 4:13 p.m. director of nursing (DON) observed R16's forehead and stated she would expect staff to be monitoring the area at least weekly to identify any changes. During interview on 8/5/15, at 7:57 a.m. RN-C observed R16's forehead and stated staff should be monitoring and assessing the area weekly to identify any changes related to the residents diagnoses and history of skin cancer in that area. The facility undated policy titled Charting Guidelines for Skin Conditions/Wounds, instructed the following:	F 309		

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- describe the type of exudate
- describe the amount of exudate
- indicate if there is tunneling or undermining
- describe any odor
- describe the wound bed
- describe the surrounding skin color
- describe the surrounding tissue/wound edges
- describe the progress of the area
- describe the treatment

R19's quarterly MDS dated 6/26/15, indicated the resident had severe cognitive impairment, and required staff assistance with transfers, dressing, toilet use, bathing, and personal hygiene.
During observation on 8/5/15, at 1:14 p.m. R19 had several bruises on her right and left upper arms. R19's bruises were numerous in color ranging from light blue to greenish, multiple size and shape, and there was no noted swelling, unusual warmth, or drainage observed.
Additionally, R19 had a skin tear, approximately the size of a dime on her right upper arm. The skin tear was undressed and left open to the air.
R19's Non-Pressure Skin Condition Report dated 7/30/15, identified R19 had a skin tear on her right forearm that measured 1.0 x 1.8 cm (centimeter), and steri-strips were applied. However, the report did not address the multiple bruising on R19's bruising on her right and left upper arms, nor did it indicate how the skin tear occurred.
R19's care plan dated 7/16/2015, did not identify any concerns of bruising.
During interview on 8/5/15, at 10:11 a.m. R19 stated she didn't know where the bruises or skin tear was from, and stated when she bruised, it can take a long time for them to go away.
During interview on 8/5/15, at 12:34 p.m.

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F 309	Continued From page 17 registered nurse (RN)-C stated she did not know where R19's skin tear or bruising came from, however, R19 frequently had bruising on her arms. RN-C was not able to locate any documentation in R19's medical record about the bruising, or the cause of R19's skin tear. On 8/5/15, at 1:39 p.m. RN-C was observed assessing R19's bruising and skin tear, which was measured as follows: An area of old bruising, with darkened skin, 6 x 4 cm and 6 x 5 cm on R19's left upper arm, with scattered dark purple bruising . Also on R19's left upper arm: one area 2 x 2 cm; a second area 1 x 1.5 cm; two additional areas, each measuring 0.75 x 1 cm and surrounded by multiple reddened purple areas measuring 1 x 2 mm (millimeter). The assessment of R19's right upper arm indicated: an area 10 x 8 cm, the bruising had multiple colors, ranging from fading yellow to dark purple, with an open area that measured 1 x 0.7 cm, triangular in shape, with an intact scab. No bleeding or drainage was noted on any of the bruises. A facility document, "Standing Orders for Wounds and Skin Care Protocols," revised 4/12/12, lacked a protocol for bruising. A facility policy on bruising was requested, but not provided.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		9/3/15

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F 323	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a side rail was securely fastened to ensure safety for 1 of 1 residents (R3) who currently utilized a side rail for bed mobility. In addition, the facility failed to ensure 1 of 1 residents reviewed with a decline in condition, (R21) was assessed to safely use the EZ stand for transfers. Findings include: R3's quarterly Minimum Data Set (MDS) dated 7/21/15, indicated he was cognitively intact, had diagnoses of Parkinson's disease (degenerative disorder characterized by tremor and impaired muscular coordination) and had a history of falls. The MDS also indicated R3 required supervision and the assist of one staff with bed mobility, had impaired functional range of motion (ROM) of the lower extremity on one side, and had problems with balance. During observation on 8/5/15, at 7:49 a.m. R3's rectangular grab bar, which was approximately 18 inches in height, was fastened to the bed frame on the exit side of the bed. When the rail was grasped, it could be pulled away from the bed to a nearly horizontal position level with the mattress. The loose rail could be moved back and forth with little effort and was not securely fastened to the bed frame. During interview on 8/5/15, at 7:50 a.m. R3 stated he used his grab bar on his bed every night to help reposition. R3 stated about a month ago he	F 323	1) Rectangular grab bar, fastened to the bed frame on the exit side of R3's bed was initially secured by Environmental Services upon discovery of being loose on 8/5/15. Since that time, the grab bar has been removed by Environmental Services upon learning that no assessment had taken place for resident to use such device. Resident does not have a need for the device at this time. R21 was admitted to Hospice on 7/6/15 & due to her declining condition, was not appropriate for a therapy referral. At the time of this observation, the RIS was not being followed by staff. RIS stated that if resident was having weakness, to use the EZ Lift (rather than the EZ Stand). R21's condition continued to decline and resident passed away on 8/25/15. Prior to her passing, her Plan of Care had been updated to reflect her decline and the EZ Stand was no longer an option for use in transferring R21. It is the expectation within the nursing dept at Mother of Mercy that staff will follow the residents' RIS/Plan of Care. Charge Nurses have been instructed to observe/monitor for compliance and to address noncompliance with staff members immediately. 2) Any resident who utilizes a grab bar &/or requires assistance with transferring	

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F 323	Continued From page 19 told the, "head nurse, the maintenance department, and several aides," the grab bar was loose and it made him, "Feel unsafe, I do not want to fall out of bed." R3 stated the facility had not tightened the grab bar although he told several staff about a month ago. During interview on 8/5/15, at 8:01 a.m. director of environmental services (ES)-A stated his department puts the grab bars on the residents' beds, however, they do not do checks of the grab bars on a regular basis to ensure they are tight, and ES-A would expect nursing would report to them if repairs were needed. ES-A looked at R3's grab bar at this time, and it stated it was loose and it needed to be tightened or replaced. R3's Restraints/Adaptive Equipment Use Assessment dated 4/26/2015, indicated "No restraints or adaptive equipment in use at this time. Will reassess quarterly and as necessary." During interview on 8/5/15, at 11:10 a.m. registered nurse (RN)-C stated R3 used a side rail on his bed and there should be a Restraint/Adaptive Equipment Use Assessment completed, however, RN-C stated R3's Restraint/Adaptive Equipment Use Assessment completed for R3 in April 2015 did not include documentation R3 had been assessed regarding the safety of the grab bars. A facility policy on side rails and restraints/adaptive equipment were requested but not provided. R21's significant change MDS dated 7/20/15, identified the resident had severe cognitive	F 323	has the potential to be affected. 3) It is the standard practice of the facility that side rails &/or grab bars are completely removed from beds and are only re-applied after appropriate assessment and indication by an RN. All nursing dept staff will be provided with additional education at mandatory meeting to be held on 9/3/15. Topics to be covered will include but not be limited to: the routine use of the RIS (Resident Information Sheet) and the expectation/importance of following the resident's Plan of Care. 4) Environmental services has added a monthly Preventative Maintenance check to ensure any/all side rails/positioning bars in use throughout the facility are secure & in proper working order. RN Unit Mgrs will observe for compliance with Plan of Care during any/all interactions with residents and follow up immediately if concerns are noted. Formal audits of compliance will occur on each Unit at least every 2 weeks x 6 weeks, and monthly thereafter. DON will designate and maintain audits.	

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impairment, and required extensive assistance with all activities of daily living (ADL's).

R21's Care plan dated 8/5/15, indicated the resident required limited to extensive assist with ADL's, and staff was directed to use the EZ stand (a mechanical device used to assist the resident to stand by applying a sling around the waist which assists the resident up to a standing position), or, if resident was having weakness use the EZ lift (a mechanical device used to transfer the resident using a sling).

During observation on 8/5/15, at 9:14 a.m. R21 was being assisted to the bathroom by two nursing assistants (NA) and registered nurse (RN)-A using the EZ stand. R21's feet were flat on the platform of the EZ stand, however, she was not bearing weight and was hanging from the sling under her armpits, and her buttocks were sagging as she was in a sitting down position.

During observation on 8/6/15, at 9:00 a.m. NA-D was alone assisting R21 to the bathroom using the EZ stand. R21 had her feet flat on the EZ stand platform, however, she was hanging from the sling under her armpits, and her buttocks were sagging as she was in a sitting down position. NA-D stated R21 is declining and has become more difficult to transfer, which she stated she had reported to nursing. NA-D stated at times she will use two staff for the transfer using the EZ stand, having one person go behind R21 to, "guide her." NA-D stated she had not ever used the EZ lift for R21, and stated, "It was difficult to transfer her [R21] today."

During interview on 8/6/15, at 9:10 a.m. NA-E stated R21 had a recent decline in condition in

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F 323	Continued From page 21 the past month, and is difficult to transfer with the EZ stand due to weakness. NA-E stated she had reported her concerns to the nurses. During interview on 8/6/15 at 9:21 a.m.., RN-B stated R21 had been walking with staff assistance about two months ago, however, R21 had a significant decline in condition and was no longer walking. RN-B was not aware if R21 had been reassessed on transfer ability since the significant decline in condition. During interview on 8/6/15, at 9:27 a.m.. certified occupational therapy assistant (COTA)-C stated therapy had not received a referral for R21 recently, and last time therapy assessed R21 she was up walking in her room. COTA-C stated she had not assessed R21 for safety using the EZ stand for transfers, however, she stated if R21 was not bearing weight, she should not be using the EZ stand. The manufacture instructions for the EZ stand dated 2005, indicated in order to use the EZ stand, patients must be able to bear some weight. A facility policy regarding transfer assessment was requested but not provided.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329		9/3/15

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F 329	Continued From page 22 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure there was specific parameters and/ or behaviors identified for administering an as needed (PRN) psychotropic medication for 1 of 1 resident, R87, reviewed who received a intramuscular PRN medication for behaviors. Findings include: R87's admission MDS dated 6/23/15, indicated the resident had severe cognitive impairment, had physical and verbal behaviors towards others in the prior 7 day look back period, and required supervision for ADL's. R87's care plan updated on 8/3/15, indicated the resident had a diagnosis of dementia with	F 329	1) Indications for use of PRN IM Haldol were obtained and added to R87's order for same on 8/3/15. The indications state PRN IM Haldol may be given for, "harmful behaviors that would cause injury to himself or others." 2) All residents who receive PRN medications have the potential to be affected. 3) Facility's "Medication Administration" policy was reviewed at Mandatory Nursing Dept Mtgs held on 8/12 & 8/13. All licensed nurses and TMA's have been provided with a copy of the facility's "Medication Administration" policy, for immediate review (8/27/15) with a	

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F 329	Continued From page 23 behavioral disturbance, anxiety, and a history of wandering. The resident had displayed aggression, inappropriate sexual comments, had recently been admitted from the behavioral health unit, is on a "variety" of psychotropic medications (no specific medications were listed), and was being followed by telepsych to assist with behavior and medication management. The care plan directed staff to administer medications as ordered, maintain a calm environment and calm approach, when resident becomes agitated attempt to redirect to a calm environment and attempt to redirect with pictures on the wall, condition of flooring, or building structure, reassure the resident that feeling upset or his anger are temporary and staff will stay with him until he feels better. During observation and interview on 8/05/2015, at 7:30 a.m. R87 was sitting in his room in the recliner. R87 was dressed, the shades were pulled, and there was no television or radio on. R87 stated he was waiting for his wife to come, and then stated he was hungry and ready to eat breakfast. R87's Resident Progress Notes indicated the following: 6/23/15- "Resident started this a.m. in an agitated state wanting to call his son, son was called and came to visit with him prior to breakfast and stayed during breakfast, resident was pleasant during this time, resident throughout the day would ask to make calls to his family and those calls were granted, resident wandered the unit going into other resident rooms... resident refused all of relief shift medications stating he had enough medicine for the week, resident	F 329	message from DON regarding specific survey findings/areas for correction. In addition, another mandatory Nurse/TMA meeting will be held on 9/3/15, during which DON or designee will provide further review of the "Medication Administration" policy as it relates to knowing why a PRN medication is being given and the documentation that must be provided. The facility's Consultant Pharmacist will also be presenting on this topic at same 9/3/15 meeting. 4) DON or designee will audit a sample of at least 6 PRN orders and related documentation weekly x 4 and randomly thereafter. Review of requirements will occur directly with individual nursing staff on an as needed basis.	

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F 329	Continued From page 24 began to get agitated after supper and demanded the staff to give him keys so he can leave off the unit; resident got upset because staff didn't give him keys so he decided to go out all of the outside doors on the unit setting off alarms several times, resident was unable to redirect, resident insisted that he was going to leave facility, resident stated that he was going to kick out the window... resident came towards staff in an angry manner stating that he wanted the keys or there will be trouble, resident pulled open locked doors and headed toward the assisted living side of the facility, staff attempted to assist him back to the secure unit and resident began to strike out at staff, staff called the police, police came and spoke with resident and he stated that he wanted to go to the hospital. Family (daughter) updated and she was against resident going to the hospital and wanted medications used to decrease agitation. On-call [physician] called and gave order for Haldol 1 mg (milligram) IM (intramuscularly) three times one day, Ativan 1 mg one time only if Haldol is ineffective. 6 staff members including 2 officers assisted with restraining resident to give him doctor order Haldol 1 mg IM right deltoid for aggressive behaviors at 10:40 p.m., medication was noted to be effective at 11:00 p.m., resident was noted sleeping in wheelchair." 7/15/15- "Resident attempted to elope from facility. Reoriented resident to person, place, time. Resident became confrontational, attempted multiple interventions, guided imagery, reorientation, distraction, no intervention succeeded. Administered 1 mg Haldol IM as per ordered." There was no documentation which identified specific behaviors which justified the IM medication was required to be given.	F 329		

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F 329	Continued From page 25	F 329		

R87's Medication Administration Record (MAR) for July, 2015, indicated the resident had an order for Haldol 1 mg IM once as needed, second dose 6-8 hours later once as needed. The diagnoses/ justification for giving the medication was listed as Dementia with behavioral disturbance. This order had a start date listed as 7/9/15.

A Telepsych initial Psychiatric Evaluation Visit Report dated 6/29/15, did not identify Haldol as a current cognitive and/or psychotropic medication that R87 had received.

A Telepsych Visit Report dated 7/6/15, did not identify Haldol as a current cognitive and/or psychotropic medication R87 had received in the past, or that it was available for staff to administer for behaviors. Medication and/or treatment recommendations included, "Physician may want to discontinue Zyprexa as a PRN medication for severe agitation since it is not recommended for that use. Instead, may consider the smallest dose of rapid acting liquid or IM Haldol to be given only in cases of severe agitation."

A Telepsych visit report dated 8/3/15 did not identify Haldol as a current cognitive and/or psychotropic medication R87 had received.

R87's current signed physician orders dated 7/16/15, indicated the resident had an order for Haldol 1 mg IM once as needed (PRN), second dose 6-8 hours later once as needed. The diagnoses for the PRN Haldol was, "dementia with behaviors." The order did not include specific parameters and/ or behaviors exhibited for staff to identify when to give the PRN medication.

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F 329	Continued From page 26	F 329		

A Physician Fax Order form regarding R87's medication dated 7/7/15, indicated, "Telepsych recommendations: May want to discontinue Zyprexa as a PRN medication for severe agitation since it is not indicated for that use. Instead, may consider the smallest dose of rapid acting liquid or IM Haldol to be given only as needed in cases of severe agitation." The physician reply back was, "I checked with pharmacy; they stated he has an IM Haldol order already; use 1 mg Haldol IM, if ineffective may repeat, use this PRN severe agitation. Although the order did not contain specific parameters or behaviors to direct staff on when to give the PRN Haldol, the resident received the IM Haldol on 7/15/15.

During interview on 8/05/2015, 7:45 a.m. licensed practical nurse (LPN)-A stated she worked with R87, and was aware of the behaviors he had in the past requiring Haldol IM to be administered. LPN-A stated she had never needed to give the resident a PRN medication for behavior, and the nurse who was working with R87 when both injections were given was no longer working at the facility. LPN-A stated she was not aware of why the Haldol IM needed to be given to R87 on 7/15/15, and stated there was no clear documentation that justified the administration, nor was there any other PRN medications available that could be used for R87 that could be given prior to R87 becoming severely agitated.

During interview on 8/05/2015, at 8:33 a.m. registered nurse (RN)-C, stated she was unable to tell from the documentation why R87 received the Haldol injection on 7/15/15, and stated there were not clear parameters for staff to determine when to give the PRN Haldol, and what specific

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F 329	Continued From page 27 behaviors R87 was displaying. The facility policy titled Medication Administration dated 12/10/12, indicated, "When administering a PRN medication you MUST know why you are giving the specific medication, example: 0.5 mg Ativan given for continued attempts to exit building. Remember to try the NON-pharmaceutical approaches and document the effectiveness before you choose to use the PRN medication. Each PRN medication given must be done by following the residents plan of care."	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 334		9/4/15

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F 334	Continued From page 28 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their Influenza/Pneumococcal Immunizations Policy in regards to Pneumococcal immunization for 1 of 5 residents (R19) reviewed for Pneumococcal immunization administration. Findings include: The facility policy titled Influenza/Pneumococcal Immunizations Policy dated 9/12, indicated, "Each resident is offered a Pneumococcal immunization, at a minimum, upon admission, unless the immunization is medically contraindicated or the resident has already been immunized... After each resident or the resident's legal representative receives education...and there is a signed consent, the vaccine will be given." R19 was admitted to the facility on 7/3/14. During review of R19's clinical record, there was no evidence the resident had received a Pneumococcal immunization. R19's Influenza/Pneumococcal Vaccination Consent form, signed by R19's Power of Attorney (POA) on 10/23/14, indicated R19 wished to have the Pneumococcal vaccination administered. An unsigned, undated, hand written note on the consent form included, "Albany Clinic has no record of [R19] ever receiving a Pneumococcal vaccine!"	F 334	1) R19 received a Pneumococcal vaccination, per her request and consent on 8/26/15. 2) All residents who desire specified immunizations have the potential to be affected. 3) It is the practice of each Unit Mgr to maintain a record keeping system to track immunizations for their respective units. All current residents' records have been reviewed by the respective RN Unit Mgrs regarding pneumococcal vaccination status. Residents are asked about vaccination status related to influenza and pneumoccal vaccinations upon admission. For those who desire and consent to a vaccination, an order will be entered into eMAR, specific to each resident, in compliance with Mother of Mercy's Standing Orders. 4) The DON or her designee will track influenza and pneumonia immunizations on a monthly basis as part of the facility Infection Control program. Immunization rates will be shared with the facility's QA committee.	

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F 334	Continued From page 30 During interview on 8/7/15, at 12:22 p.m., registered nurse (RN)-E stated R19's POA had indicated R19 wished to have the Pneumococcal vaccine, however, she was unable to find evidence in R19's clinical record the resident had received the vaccine. RN-E stated the Pneumococcal vaccine was not documented as being administered in R19's clinical record, so the facility must have missed giving it to the resident.	F 334		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental services were provided for 1 of 1 resident, (R81) who requested dental services. Findings include: R81's quarterly Minimum Data Set (MDS) dated 8/3/15, indicated the resident had no cognitive impairment, had no problems with his teeth, had no swallowing problems, and was on a mechanically altered diet.	F 412	1) Social Services dept has been in contact with resident's niece and responsible party, R81's Care Coordinator from BCBS insurance company, and R81 to determine R81's current wishes re: dental care and to find dental providers who will accept R81's insurance coverage for treatment. Dental appt is currently scheduled for 8/31/15.	8/31/15

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F 412	Continued From page 31 R81's care plan dated 5/18/15, indicated the resident had his own teeth and a partial denture which he did not want to wear. This care plan also indicated R81 was on an advanced dysphasia diet defined as a diet which includes meats that have the consistency of ground hamburger fried in a pan, diet is nearly the same as a regular diet with the exception of the meat products and a few others. On this diet the meats must be ground with gravy on top--not just mixed with the meat, and fresh apples, grapes, pineapple, pears, cantaloupe/honeydew, hard berries, raw veggies like lettuce, cabbage and cucumbers are not allowed; and hard food items like chips, popcorn, hard French fires, hard cookies and peanuts should be avoided. R81's nutrition assessment dated 5/4/15, indicated the resident was on an advanced dysphasia diet and had some natural teeth, and does not use a partial plate (dentures). During observation and interview on 8/3/15, at 4:00 p.m. R81 was noted to have many missing lower teeth, and R81 stated he has five or six teeth on the his bottom jaw, and he had a plate (dentures), but it started to rub so he no longer wears it. R81 stated that he has not worn his dentures or seen the dentist in about a year. R81 stated he cant eat all of the foods he would like to eat because he is not able to chew them without dentures, and he stated he should see a dentist, however, staff had not set up any appointments for him to be seen. During interview on 8/6/15, at 8:40 a.m. registered nurse (RN)-C stated she was not sure why the initial MDS for R81 did not indicate he had any dental problems because R81 refused to	F 412	2) Any resident who desires dental care has the potential to be affected. 3) Post care conference follow up, including conversations, referrals, appts, as well as a resident's declination of referrals or appts, etc will be documented in the resident record. Facility is currently researching possibilities for on-site dental services in the future. 4) Social Services Director or designee will review quarterly, or as needed, to ensure any desired referrals have been made per the resident's wishes. In the event a resident's wishes change, and staff are notified of said change, this will be documented in the resident record as well.	

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F 412	Continued From page 32 wear his dentures, however, she was not sure why he refused to wear them. RN-C stated dental appointments are offered to residents upon admission and quarterly by social services. RN-C reviewed R81's medical chart and indicated the resident had not seen the dentist since admission to the facility on 10/29/14. R81's quarterly Care Conference charting notes dated 11/18/15, and 2/4/15, indicated R81 did not wish to see dentist or doctor. However, A care conference note dated 5/19/15, indicated the resident was recently to the eye doctor, and needed to see the dentist to have dentures realigned. R81's medical record did not indicate the facility followed up on the request for R81 to see a dentist. During a follow up interview on 8/6/15, at 8:54 a.m. R81 stated his old dentures were wearing on his gums and that is why he did not wear them. He stated he would like to get them fixed, however, the facility had not asked him about going to the dentist and he was not aware of how to set up an appointment. During interview on 8/6/15, at 2:24 p.m. RN-C stated R81 had not seen the dentist since he had requested to be seen at the care conference on 5/19/15. A copy of the facility dental policy was requested but not provided.	F 412		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		9/3/15

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F 425	Continued From page 33 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure administration of an inhaler according to manufacturer recommendations for 1 of 7 residents (R10) observed. Findings include: R10's annual Minimum Data Set (MDS) dated 6/18/15, indicated the resident had severe cognitive impairment. R10's Physician Order Report dated 8/4/15, noted diagnosis of chronic airway obstruction and asthma, and R10 received Advair Diskus, 1 inhalation, two times daily for chronic airway obstruction.	F 425	1) TMA-A was re-educated in person by DON on 8/10 regarding need for R10 and any residents receiving Advair or other steroid inhalers, to rinse their mouths following administration. 2) All residents who receive steroid inhalers have the potential be affected. 3) A mandatory Pharmacy Inservice for nurses and TMAs will be provided by facility's consultant pharmacist on 9/3/15 to review administration of medications with special instructions. Coritcosteroid inhalers will have an additional instruction entered into eMAR,	

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 _____	08/07/2015

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 425	Continued From page 34 During observation on 8/7/15, at 8:03 a.m. trained medication aid (TMA)-A administered Advair Diskus 1 inhalation, but did not offer water for R10 to rinse her mouth afterward. During interview on 8/7/15, at 8:19 a.m. TMA-A stated she had forgot to offer water to R10 after the inhaler so she could rinse her mouth, and stated she was instructed residents are to rinse their mouth after using the Advair Diskus inhaler. During interview on 8/7/15, at 8:30 a.m. registered nurse (RN)-B stated a rinse should be provided after administering Advair Diskus. During interview on 8/7/15, at 12:05 p.m., RN-C stated a mouth rinse should be provided to residents after administration of Advair Diskus, and this should be noted on the administration record. The Advair diskus inhaler informational website indicated the medication can cause a "fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using ADVAIR to help reduce your chance of getting thrush." A facility policy was requested but not provided.	F 425	"Rinse mouth after administration," with each applicable order to alert the nurse/TMA to same. In addition, the facility's "Medication Administration" policy will be updated to reflect special administration considerations. Education on policy updates to be provided to nurses/TMA's on 9/3/15. 4) Medical Records will perform monthly audits to ensure this direction is included for all applicable meds.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		9/3/15

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 431	Continued From page 35 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication labels matched the physician order after a change in dose was made for 1 of 7 residents (R10) observed for medication administration. Findings include: During observation of medication storage in the	F 431	1) Per the facility "Medication Administration" policy, a green "change" sticker was applied to the medication label on R10's Flonase bottle. 2) All residents who receive medications have the potential to be affected. 3)TMA-A was re-educated in person by	

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F 431	Continued From page 36 second floor medication cart on 8/6/15, at 9:05 a.m. a bottle of Flonase had a label which indicated two sprays each nostril two times daily for R10. The medication administration record (MAR) indicated one spray each nostril two times daily. R10 also had a bottle of Tylenol 500 milligram (mg) tablets, and the label on the bottle indicated two tablets to be given three times daily, and the MAR read 1-2 tablets orally three times a day. During interview on 8/6/15, at 9:05 a.m. trained medication aid (TMA)-A stated when there is a dose or direction change with a medication, staff should be notifying the nurse to apply a new label which matches the actual physician order. During interview on 8/7/15, at 12:09 p.m. registered nurse (RN)-C stated the bottles should have a green sticker on them, noting the dosage change or change instructions. During interview on 8/7/15, at 1:16 p.m. RN-F stated a medication with a dose change ordered should have a green sticker on the bottle, otherwise pharmacy could provide a new label. The facility policy titled Medication Administration dated 12/10/12, noted if there is any discrepancy between the MAR and the label, check the orders before administering medication. If the label is wrong, send medication to the pharmacy for relabeling, or place a green sticker that states, "Direction change refer to med sheet."	F 431	DON on 8/10 re: proper procedure when medication labels do not match the MAR. She acknowledged understanding. Facility's "Medication Administration" policy was reviewed at Mandatory Nursing Dept Mtgs held on 8/12 & 8/13. All licensed nurses and TMA's have been provided with a copy of the facility's "Medication Administration" policy, for immediate review (8/27/15) with a message from DON regarding specific survey findings/areas for correction. In addition, another mandatory Nurse/TMA meeting will be held on 9/3/15, during which DON or designee will provide further review of the "Medication Administration" policy, which includes directions to compare the pharmacy label to the MAR, and what to do if there is a discrepancy regarding same. 4) Auditing: DON will choose 2-4 residents on a monthly basis x 3 months for auditing of pharmacy labels. The audits may be completed by DON or her designee.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		9/11/15

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F 441	Continued From page 37 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 441	1) Mother of Mercy expects all nursing	

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F 441	Continued From page 38 review, the facility failed to ensure appropriate hand hygiene and infection control practices were utilized while providing personal cares for 1 of 4 residents, (R1) observed being provided personal cares. Findings include: During observation on 8/5/15, at 8:12 a.m. nursing assistant (NA)-N, nursing student (NS)-A, and NS-B assisted R1 to his wheelchair from the bed with the EZ lift hoyer (a mechanical lift used to transfer a resident). Before transferring R1, the tubing was unhooked from R1's tracheostomy, and the tubing fell onto the floor. After staff transferred R1 in his wheelchair, the tubing was picked up off the floor, and placed back onto R1's tracheostomy without cleaning it. During another observation on 8/6/15, at 7:22 a.m. NA-N entered R1's room to changed the residents incontinent pad. NA-N donned clean gloves, and brought a clean incontinent pad and wipes to the bedside. NA-O entered the room to assist, donned clean gloves, assisted to turn R1, and provided incontinence care by cleaning R1's buttocks. Without changing gloves or performing hand hygiene, NA-O touched R1's shoulder, raised the head of the bed, placed a pillow under R1's right side, grabbed the washcloth, and washed the site under the tracheostomy. During another observation on 8/6/15, at 8:52 a.m. NA-N and NA-O changed R1's urine soaked incontinent product. After removing R1's wet pants, NA-N placed them on the dresser near the residents soft splints used for his hands, the radio, and a bottle of lotion. Several minutes later the wet incontinent pad was removed from the	F 441	dept staff to provide care in a manner consistent with applicable policies and procedures, as well as per current standards of practice. 2) These observations have the potential to affect all residents. 3) All nursing dept staff received notice on 8/27/15 from DON regarding specific survey findings and the need for immediate correction of stated items. Mandatory education for all nursing dept staff on 9/3/15 will include, but not be limited to, the topics of Hand Hygiene and Basic Infection Control. This education will be presented jointly by the Staff Development Coordinator and the DON. The facility will continue to utilize online, interactive educational modules for periodic review of these topics. Residents who require a hoyer lift for transfer are assigned their own designated slings for use. As resident contact does not occur during use of the lift, the lift itself in not routinely cleaned between each resident use. Specific orientation content regarding hoyer use & care will be reviewed by Staff Development Coordinator and DON and updated as needed. 4) Direct care audits will occur on each Unit at least every 2 weeks x 6 weeks and monthly thereafter. Audits will include observation of hand washing procedures and any applicable infection control practices. DON will designate and	

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F 441	Continued From page 39 dresser and placed on top of a stool with a cushioned cloth seat. NA-O and NA-N then changed gloves, without first performing hand hygiene, and NA-N hooked the hoyer sheet to the stand using bare hands. After transferring R1 to the wheelchair, NA-O touched the bathroom door, the oxygen tank, the oxygen tubing, and hooked it to the tracheostomy still without completing any hand hygiene. NA-N removed the EZ lift hoyer from R1's room and placed it outside the door without wiping it off. During interview on 8/6/15, at 7:36 a.m. NA-O stated hand hygiene and a applying clean gloves should have been completed after doing perineal care on R1. When interviewed on 8/6/15, at 9:48 a.m. NA-N stated hand hygiene should be completed after removing gloves, and stated he was unsure of what to do when the vent tubing fell on the floor. During interview on 8/6/15, at 10:12 a.m. registered nurse (RN)-C stated hand hygiene after providing incontinence care would include hand hygiene and a glove change, and hand hygiene is taught in orientation with staff development director (SD). RN-C stated staff should not be placing a soiled incontinent product or clothing on the nightstand or stool. When interviewed on 8/6/15, at 2:46 p.m. SD-A stated hand hygiene education is provided on the first day of orientation, and the policy is reviewed. SD-A stated random audits are completed, and if not done appropriately, reeducation is provided. However, there is no routine schedule for this, nor do each staff get observed on a routine basis. SD-A stated use of the hoyer is taught in the	F 441	maintain audits.	

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F 441	Continued From page 40 orientation also, and they discuss cleaning the hoyer between each resident use. The facility policy titled Handwashing dated 11/02, noted handwashing should be performed when coming on duty, before going home, at the end of the shift, after using the toilet facilities, after using the toilet facilities, after sneezing, coughing, etc., before and after eating, and any other time that contamination may have taken place. The facility policy titled Standard Precautions dated 2010, noted standard precautions include hand hygiene, use of gloves...properly cleaning and disinfecting or sterilization for reusable equipment before use on another patient.	F 441		

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 _____	**08/04/2015**

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K 000	INITIAL COMMENTS Fire Safety A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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: PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Pat.Sheehan@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.	K 000	EPOC	

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

Electronically Signed | 08/26/2015

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 _____	**08/04/2015**

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K 000	Continued From page 1 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 76 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by:	K 067		9/4/15

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K 067	Continued From page 2 Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On 08/04/2015at 10:00AM, during an interview with facility staff, it was confirmed the HVAC system does contain one or more fire/smoke dampers, however, no documentation could be provided verifying the fire/smoke dampers were inspected and tested within the previous 4 years, in accordance with NFPA 90A [1999] Chapter 3, Section 3-4.7. This deficient practice was verified by the Director of Environmental Services (RZ)..	K 067	The fire/smoke dampers will be inspected and tested on 9/3/2015 by Tyco Simplex Grinnell in accordance with NFPA 90A (1999) chapter 3, section 3-4,7. Ron Zierden, Environmental Services Director will be responsible for correction of this tag. Ron will add the 4 year interval inspection and testing of fire/smoke dampers to our online Preventative Maintenance Program (Facility Dude) to monitor and prevent a reoccurrence of this deficiency.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY	K 144	Documentation of weekly generator	9/4/15

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K 144	Continued From page 3 REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, the facility did not perform weekly inspections from 11/18/2014 - 12/11/2014, 12/19/2014- 01/24/2015 and 02/02/2015-02/18/2015 for the emergency generator. In a fire or other emergency, this deficient practice could adversely affect all residents, staff and visitors. This deficient practice was verified by the Maintence Director (RZ).	K 144	inspection will be completed ongoing, and exercised under load at not less than 30% of the EPS nameplate rating. Ron Zierden, Environmental Services Director will be responsible for correction of the tag. Ron will add the weekly (and monthly) generator inspection to our online Preventative Maintenance Program (Facility Dude) to monitor and prevent a reoccurrence of the deficiency.	

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	245339	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/04/2015**

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K 000	INITIAL COMMENTS Fire Safety A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. 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. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2015

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 **01 - MAIN BUILDING 01** B. WING _____	**08/04/2015**

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 1 ST. Paul, MN 55101-5145 Pat.Sheehan@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	K 000		

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K 000	Continued From page 2 Sprinkler Systems (1999 edition) The facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The facility has a licensed capacity of 76 and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it could not be verified whether the facility's general ventilating and air conditioning system (HVAC) was maintained in accordance with NFPA 101 (2000) Chapter 19, Section 19.5.2.1 and Chapter 9, Section 9.1 and NFPA 90A [1999]. In a fire emergency, a noncompliant HVAC system could adversely affect all residents, staff and visitors. FINDINGS INCLUDE: On 08/04/2015 at 10:00AM, during an interview with facility staff, it was confirmed the HVAC	K 067	The fire/smoke dampers will be inspected and tested on 9/3/2015 by Tyco Simplex Grinnell in accordance with NFPA 90A (1999) chapter 3, section 3-3,7. Ron Zierden, Environmental Services Director will be responsible for correction of this tag. Ron will add the 4 year interval of inspection and testing of fire/smoke dampers to our online Preventative Maintenance Program (Facility Dude) to monitor and prevent a reoccurrence of the deficiency.	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 067	Continued From page 3 system does contain one or more fire/smoke dampers, however, no documentation could be provided verifying the fire/smoke dampers were inspected and tested within the previous 4 years, in accordance with NFPA 90A [1999] Chapter 3, Section 3-4.7. This deficient practice was verified by the Director of Environmental Services (RZ)..	K 067		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, the facility did not perform weekly inspections from 11/18/2014 - 12/11/2014, 12/19/2014- 01/24/2015 and 02/02/2015-02/18/2015 for the emergency generator. In a fire or other emergency, this	K 144	Documentation of weekly generator inspection will be completed ongoing, and exercised under load at not less than 30% of the EPS nameplate rating. Ron Zierden, Environmental Services Director will be responsible for correction of this tag. Ron will add the weekly (and monthly) generator inspection to our online Preventative Maintenance Program (Facility Dude) to monitor and prevent a reoccurrence of the deficiency.	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 4 deficient practice could adversely affect all residents, staff and visitors. This deficient practice was verified by the Maintence Director (MH).	K 144		