

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered July 2, 2021

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

RE: CCN: 245339 Cycle Start Date: April 22, 2021

Dear Administrator:

On June 22, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Mi This

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 10, 2021

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

RE: CCN: 245339 Cycle Start Date: April 22, 2021

Dear Administrator:

On April 22, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor St. Cloud B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: susie.haben@state.mn.us Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 22, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 22, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

Mother Of Mercy Senior Living May 10, 2021 Page 4 Feel free to contact me if you have questions.

Sincerely,

5 6

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

cc: Licensing and Certification File

		& MEDICAID SERVICES				RM APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		\G		OMPLETED
		245339	B. WING			С
	PROVIDER OR SUPPLIER	245339	B. WING -	STREET ADDRESS, CITY, STATE,		04/22/2021
				230 CHURCH AVENUE, BOX 67		
MOTHER	R OF MERCY SENIOR	LIVING		ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
	survey was conduct was found to be NC requirements of 42 Requirements for L The following comp SUBSTANTIATED: H5339030C (MN00 cited at F656 and F H5339031C (MN00 cited at F609, F656 The facility's plan of as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an onsite revisit of you validate that substat regulations has beet Reporting of Alleget CFR(s): 483.12(c)(1) §483.12(c)(1) Ensu	072010), with deficiencies 6, and F755. f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an r facility may be conducted to initial compliance with the en attained. d Violations 1)(4) onse to allegations of abuse, n, or mistreatment, the facility re that all alleged violations	F 60	09		4/26/21
	involving abuse, ne mistreatment, inclu source and misapp	glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2				
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 05/20/2021
	lically olyneu					03/20/2021

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

DEDARTMENT OF LIEALTH AND LUMANN SERVICES

PRINTED: 06/15/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2021 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE COMF	SURVEY	
		245339	B. WING	i		04/2	<i>;</i> 2/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MOTHER	OF MERCY SENIOR	LIVING			30 CHURCH AVENUE, BOX 676 ALBANY, MN 56307	X 676		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 609	that cause the alleg serious bodily injury the events that cause abuse and do not re- the administrator of officials (including tr- adult protective ser- for jurisdiction in lor accordance with Sta- procedures. §483.12(c)(4) Repo- investigations to the designated represe accordance with Sta- Survey Agency, with incident, and if the a appropriate correction This REQUIREMEN by: Based on interview facility failed to repo- theft to the State Age the allegation for 1 for misappropriation Findings include: R1's quarterly Minin 1/19/21, identified F required limited to e activities of daily live included congestive obesity, and spondy MDS indicated R1 F as needed pain me medication having F	ation is made, if the events lation involve abuse or result in <i>x</i> , or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other the facility and to other of the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established ate law through established of the results of all e administrator or his or her ntative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ve action must be taken. NT is not met as evidenced of and document review, the ort allegations of medication gency (SA) within 24 hours of of 1 residents (R1) reviewed	F	609	F - 609 The error of not reporting has been corrected by the following: The Director of Nursing who submitte report has reviewed the Department Health protocols and reviewed the protocols with the Nurse Managers, have access to report. In addition, the nurse who waited to a to anyone was instructed and reminor that she needed to report as soon as discrepancy was found. The Director of Nursing will monitor to all protocols are followed in the future	of who report ded s a that		

Facility ID: 00634

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		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245339	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR	LIVING			30 CHURCH AVENUE, BOX 676 LBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	and day to day activ	vities.	F6	609	This was corrected on 04/26/2021.		
	4/19/21, at 1:11 p.m (DON). The inciden of medication negle accurate reconciliat (opioid pain medica however, on 4/17/2 count was observed "short." Further, the	s submitted to the SA on h. by the director of nursing at report identified an allegation act in which R1 had an tion of her liquid Oxycodone ation) on 4/16/21 at 2:00 p.m.; 1, at 6:00 a.m. the Oxycodone d to be three milliliters (ml) a report identified R1 had adone doses and no injury to			Paul Gaebe, Administrator, will be responsible that the Director of Nur ensures that the reporting is compl within 24 hours.		
	registered nurse (R around 6:00 a.m. sl nurse (LPN)-A appr cart to start the shif counting process, in Oxycodone packag narcotic drawer and Oxycodone count) of the bottle of medica for counting. RN-A the DON shortly aft discrepancy as she being she had been investigation at that of diluted liquid Mon for a different residu update a manager away" if she were to discrepancy as they they needed to report theft to the SA.	4/21/21, at 12:38 p.m. N)-A stated on 4/17/21, he and licensed practical oached the floor's medication t to shift controlled medication n which LPN-A removed R1's ing box from the cart's d explained to RN-A "it [the was off" before she had pulled ation out of the packaging box explained she had contacted er she observed the had "took it more serious" n aware of an ongoing time related to an allegation rphine (opioid pain medication) ent. RN-A stated she was to or the on-call nurse "right of find a controlled medication y had time frames for when ort allegations of medication					

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIDI	LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
			_			(С
		245339	B. WING				22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
MOTHER	OF MERCY SENIOR			2	230 CHURCH AVENUE, BOX 676		
	OF MERCI SENIOR	LIVING		A	ALBANY, MN 56307		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
1710		,			DEFICIENCY)		
F 609	Continued From pa	ge 3	F 6	09			
		s to contact the on-call nurse					
		"considerable" medication					
		en found. The ADON denied cy which provided information					
		s considered a reportable					
		ancy amount and had been					
		at a considerable medication					
		consist of; however, she					
		be "based on the nurses ." The ADON verbalized she					
		ed the on-call nurse to have					
		t the Oxycodone discrepancy					
	the evening of 4/16	/21 as allegations of					
		quired reporting to the SA					
	within two hours of	the allegation.					
	During interview on	4/21/21, at 3:26 p.m. unit					
		ated if a liquid medication					
		ound of a "ml or more" it					
		nto a medication cup and ringe to ensure accuracy and					
		urther reconciliation. RN-B					
	•	three ml discrepancy would be					
	"concerning" to her	and would rise to the level of					
	. , ,	to be reported to the SA "in					
	less than 24 hours.	"					
	When interviewed v	/ia telephone on 4/21/21, at					
		ssistant (NA)-A stated on the					
	evening of 4/16/21	she had overheard LPN-B tell					
		s off by a bit" when she had					
		they stood at the medication					
	cart.						
	During interview via	a telephone on 4/22/21, at 8:21					
		she had visualized R1's liquid					
		ss than the narcotic book					
		nt when she and LPN-B					
1	performed the 4/16	/21's evening shift to shift					

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PRINTED: 06/15/2021

		AND HUMAN SERVICES					FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTIO	DN		(X3) DATE COMI	E SURVEY PLETED
		245339	B. WING _		<u></u>			C 22/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS	, CITY, STATE, ZIP	CODE		
MOTHER	R OF MERCY SENIOR	LIVING		230 CHURCH AVE ALBANY, MN 5	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CC ORRECTIVE ACTIO FERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 609	controlled medication stated LPN-B had end been "off a couple of indicated she had a medication back in in the plastic medic however LPN-B had any." LPN-A acknow been off approximate explained she had of with LPN-B and had to any of the other of on-call nurse, or face confirmed the first to reported to manage morning of 4/17/21 DON after that mor LPN-A acknowledge abuse which include explained abuse was minimum of two hole When interviewed of DON stated at the to R1's medication diss "necessarily" suspet to further investigate what had occurred, have not been a rep explained she under reporting of medication she should have read discrepancy to the states. An Abuse Prevention Procedure policy, do of its intents was to investigating and read	on counting process. LPN-A explained the medication had of ml's" in which LPN-B attempted to pour the the bottle after some had spilt cation syringe holding sleeve; d been unable to "salvage wledged the Oxycodone had ately three ml's. LPN-A not followed up more on this d not reported the discrepancy nurses working that shift, the cility management. LPN-A time the discrepancy was ement had been on the when RN-A contacted the ning's shift to shift count. ed having been trained on ed medication theft and as to be reported within a urs to her supervisor. on 4/22/21, at 9:11 a.m. the time of her being notified of acrepancy she had not ected theft and she had wished the the situation to determine such as spillage, which would portable situation. The DON erstood timelines for SA ation theft allegations and that ported R1's medication	F 60	9				

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STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY MPLETED
	JI CONNECTION			IG		C
		245339	B. WING			/22/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
MOTHER	R OF MERCY SENIOR	LIVING		230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
	include abuse, neg misappropriate of p misappropriation of exploitation include policy directed all s and/or maltreatmer which an initial onlin immediately but no whether the abuse substantiated or no staff, "When in dou the administrator is Develop/Implement CFR(s): 483.21(b)(§483.21(b) Compre §483.21(b)(1) The implement a compre care plan for each resident rights set f §483.10(c)(3), that objectives and time medical, nursing, a needs that are iden assessment. The c describe the followi (i) The services that or maintain the resi- physical, mental, an required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized	lect, financial exploitation, and property in which f resident property/financial d resident medications. The uspected abuse, neglect, int to be reported promptly in ne report must be made later than two hours to the SA and/or neglect was it. Further, the policy directs bt be sure to report," and that to be notified immediately. t Comprehensive Care Plan 1) ehensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable eframes to meet a resident's nd mental and psychosocial tified in the comprehensive comprehensive care plan must ing - it are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not e resident's exercise of rights luding the right to refuse 83.10(c)(6). services or specialized tes the nursing facility will	F 60			5/21/21

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		<u>3 NO. 0938-</u> 3) date surve		
	OF CORRECTION	IDENTIFICATION NUMBER:	· · /		COMPLETED		
					С		
		245339	B. WING		04/22/202	:1	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MOTHER	R OF MERCY SENIOR	LIVING		230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETION	
F 656	Continued From pa	ge 6	F 656				
	findings of the PAS. rationale in the resi (iv)In consultation v resident's represen (A) The resident's g desired outcomes. (B) The resident's g future discharge. Fa whether the resider community was ass local contact agence entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on interview facility failed to dev comprehensive car R2) who did not hav comprehensive car 21 days following a remain consistent v R1's quarterly Minin 1/19/21, identified F 10/12/20. Further, t intact cognition, imp required limited to e activities of daily liv in hospice care. Dia heart failure (CHF), spondylosis (neck a	poals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to sies and/or other appropriate		F: 656 Correction for F656 -second submiss 6/9/2021 Resident 1 had no apparent ill effects from the suspected dilution or discrep in count, including any increased pair she was and still remains on hospice. scheduled oxycodone, rarely takes pr Resident 2 had no apparent ill effects from the suspected dilution of her morphine, it is prn and she does not t very often ask for it, during the time o diluting, and ongoing. Both residents 1 and 2 had a complet RIS care plan (Resident Instruction sl that the aides use, and all needs were	bancy n, . Has m. ake f the ted heet)		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245339	B. WING				C 22/2021
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	OF MERCY SENIOR	LIVING			30 CHURCH AVENUE, BOX 676 LBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	anti-anxiety, and an medications. R1's s impacted her sleep activities, along with In addition, R1 had On 4/21/21, at 11:00 record (EMR) was r following comprehe categories: - Pressure ulcer, sta - Activities, start dat - Nutritional status, - Skin tear injury ris On 4/21/21, around a paper copy of R1' which identified the categories: - Pain, reviewed/rev - Adaptive Equipme 4/21/21, at 12:03 p. - Hospice, reviewed/rev	along with the use of diuretic, ticoagulant (blood thinner) elf-reported frequent pain and limited her day to day mild depression symptoms. bladder incontinence. 5 a.m. R1's electronic medical eviewed and identified the nsive care plan problem art date 11/2/20. e 1/19/21. start date 2/2/21. k, reviewed/revised on 4/7/21. 1:00 p.m. the ADON provided s comprehensive care plan following additional problem rised on 4/21/21, at 11:50 a.m. m. l/revised on 4/21/21, at 12:07 rised on 4/21/21, at 12:11 p.m.	F	\$56	were met in relation to the late com of the full care plan, medications, assessments, and reported on shift shift with any issues or changes. The full care plans are completed b RN managers on each unit. They al trained in the MDS process. Each of managers was given cc of the RAI summary of required due dates for completion of care plans to review. attached labeled F-656 RAI) In order to better track compliance timely completion of care plans, a c has been added to MDS schedule v place to put in date completed . Thi be audited weekly by the DON for 2 months, and then spot checked if a compliance. (previously attached) All of above in place as of 5/21/202 Compliance will be monitored by Su Roberts BSN, RN, DON	to y the re fully of the OBRA (cc with column with a s will ll in 1 usan M	
	at 12:28 p.m. - ADL (activities of or rehabilitation potent transfers, toileting, j dressing, bed mobil on 4/21/21, at 12:28 R1's medical record centered comprehe preference and goal address the resider	l lacked a completed person nsive care plan to meet R1's ls, which were measurable to t's overall medical, physical,			Going forward, there will be an addi column on the MDS schedule, indic "Date Completed" for the comprehe Care Plan. (See attachment). These schedules will be reviewed a monitored by the Director of Nursing corrective actions will be taken if ne This system will be in place on or be 05/21/2021.	eating ensive and g and eeded. efore	
	mental and psychos				Susan Roberts, BSN, RN Director of	л	

Facility ID: 00634

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· í			(X3) DATE	E SURVEY PLETED
		245339	B. WING	<u> </u>			
NAME OF F	ROVIDER OR SUPPLIER	240000		ST	REET ADDRESS, CITY, STATE, ZIP CODE	04/4	22/2021
					0 CHURCH AVENUE, BOX 676		
MOTHER	OF MERCY SENIOR	LIVING			LBANY, MN 56307		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX			PREFIX	((EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
			1	_			
F 656	Continued From pa	ae 8	F 6	56			
		3			Nursing will be responsible.		
	R2's quarterly MDS	, dated 1/28/21, identified R2			· · · · · · · · · · · · · · · · · · ·		
		lity on 8/27/20. Further, the					
		nad moderately impaired					
		hearing and vision, required assist for ADL's, and was					
		care. Diagnosis included					
	•	dysphagia, hemiplegia (left					
	sided weakness) af	ter a cerebrovascular accident					
		ain, and a wedge compression					
		ar (lower) vertebrae (spine). R2 had received scheduled					
		medication with an opioid					
		ving been administered, along					
	with antidepressant						
		ional pain limited her day to					
		with mild depression					
		on, the MDS identified R2 had					
		incontinence, held food/food outh after meals, and utilized					
	bed and chair alarm						
		1 a.m. R2's electronic medical					
		reviewed and identified the					
	categories:	nsive care plan problem					
		reviewed/revised 10/29/20.					
		k, reviewed/revised 11/12/20.					
	- Hospice, reviewed	l/revised on 3/18/21.					
	- Falls, reviewed/rev						
	- Skin tear injury ris	k, reviewed/revised 4/13/21.					
	On 4/21/21, around	1:00 p.m. the ADON provided					
		's comprehensive care plan					
	which identified the	following additional problem					
	categories:						
		vised on 4/21/21, at 12:44 p.m.					
	at 12:57 p.m.	ce, reviewed/revised 4/21/21,					

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PRINTED: 06/15/2021

		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245339	B. WING	;			C 22/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR	LIVING			230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	 ADL functional / reindividual areas of vitoileting, personal himobility, bathing, rei 12:57 p.m. R2's medical record centered comprehe preference and goar address the resider mental and psychos During interview on assistant director of Nurse Manager for admission a resider plan was to be com admission MDS have explained she and to (RN) Managers were process was complianed she and to (RN) Managers were process was complianed she and to (RN) Managers were process was complianed she and to (RN) Managers were process was complianed she and to (RN) Managers were process was complianed she and to (RN) Managers were process was complianed she and to (RN) Managers were process was complianed she and to (RN) Managers were provide the best incorresident they could. comprehensive carreviewed/revised da initially developed a day. The ADON confirmed comprehensive carreviewed/revised da initially developed and day. The ADON act incomplete comprehensive carreviewed/revised da initially developed and day. The ADON act incomplete comprehensive carreviewed/revised da initially developed and day. The ADON act incomplete comprehensive carreviewed/revised da initially developed and day. The ADON act incomplete comprehensive carreviewed/revised da initially developed and day. The ADON act incomplete comprehensive carreviewed/revised da initially developed and day. The ADON act incomplete comprehensive carreviewed/revised da initially developed and day. The ADON act incomplete comprehensive carreviewed/revised da initial admission constraints" related main reason for the care plans. She derivative care plans. She derivative care plans area care plane. 	ehabilitation potential for walking/wheeling, transfers, hygiene, eating, dressing, bed eviewed/revised on 4/21/21, at d lacked a completed person ensive care plan to meet R2's als, which were measurable to ht's overall medical, physical, social needs. 4/21/21, at 2:11 p.m. the f nursing (ADON)(Registered third floor), stated after nt's initial comprehensive care apleted within 14 days after the d been due. The ADON the other Registered Nurse re responsible to ensure this leted in order for the facility to dividualized care for each . Further, she explained the e plan was to be reviewed uarterly MDS process and with enced changes in condition. ed R1's and R2's	F	656			

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		AND HUMAN SERVICES			FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245339	B. WING			C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR	LIVING		230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	plans were complet frames. When interviewed of stated the RN Mana develop a resident's after their admission expect to see items from the admission as resident impairm she would have exp comprehensive carr as needed for resid October of 2020, es should have had the quarterly after their facility had an audit comprehensive carr required time frame A Mother of Mercy O 11/2017, identified t resident-centered p each resident which preferences and str expressed needs, v and supports, plan timeframe's related recovery. The policy Manager completed resident within 21 d they would ensure p Care based on the when there were cl interventions identif changes in the Res	ted within required time on 4/21/21, at 3:26 p.m. RN-B agers have three weeks to s comprehensive care plan n. She explained she would on the care plan triggered MDS process or items such hents. Further, RN-B explained bected to see a e plan developed and revised lents admitted in August and specially since these residents eir care plans reviewed admissions. RN-B denied the ing process in place to ensure e plans were completed within es. Care Planning policy, revised the facility would ensure a blan of care was developed for n included the resident's goals, rengths, assessed and which identified key networks hed interventions, and to treatment, wellness and y directed the RN Unit d a Plan of Care for each lays of the admission date and periodic review of the Plan of Resident's individual needs hanges in goals, objectives, or fied, when warranted by ident's medical or behavioral ad must be reviewed quarterly	F 65	,		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/15/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ´		E CONSTRUCTION (COM	E SURVEY PLETED C
		245339	B. WING	i			22/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	OF MERCY SENIOR	LIVING			30 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued From pa	ae 11	F	755			
F 755		ocedures/Pharmacist/Records		755			4/22/21
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin permits, but only un a licensed nurse. §483.45(a) Procedu	ovide routine and emergency als to its residents, or obtain eement described in cility may permit unlicensed ister drugs if State law oder the general supervision of ures. A facility must provide					
	that assure the acc dispensing, and ad	vices (including procedures urate acquiring, receiving, ministering of all drugs and t the needs of each resident.					
		Consultation. The facility ain the services of a licensed					
		ides consultation on all ision of pharmacy services in					
		blishes a system of records of tion of all controlled drugs in nable an accurate					
	order and that an a is maintained and p	rmines that drug records are in ccount of all controlled drugs periodically reconciled. NT is not met as evidenced					
	Based on interview facility failed to ensu	<i>i</i> and document review, the ure nursing staff followed ds of practice for the			F:755 There were 2 medication issues brow	uaht	
	assoptable standar					agin	

Facility ID: 00634

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED	
		245339	B. WING			C	
	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP CODE	04//	22/2021	
	R OF MERCY SENIOR	LIVING		230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 755	administration of na controlled substand classified by the Dr in a manner to prev 2 of 2 residents (R misappropriation of facility failed to hav process in place to unusual patterns re controlled medicati reconciliation, and Findings include: R1's quarterly Minit 1/19/21, identified I required limited to activities of daily liv in hospice care. Dia heart failure (CHF) spondylosis (neck a R1 had received so medication with an been administered pain impacted her day activities. An initial report was Agency (SA) on 4/2 director of nursing identified an allega financial exploitatio R2's liquid Morphin suspected to have someone to "steal" Morphine "should her should her someone to "steal"	arcotic medication and/or ces (medications regulated and rug Enforcement Agency (DEA) vent potential drug diversion for 1, R2) reviewed for f property. In addition, the re a systematized oversight identify discrepancies and elated to narcotic and	F 75	 to the attention of the Director of and the Assistant Director of Nurs. The first was a suspicion of dilutional liquid Morphine and possibly liqui Oxycodone. The second involved discrepancy of approximately 3 m the same liquid Oxycodone. The had been replaced previously, an were told by Pharmacy that there any way to check potency. The second event was a relief sh and a night Nurse were doing the the night Nurse reported that the Nurse stated that the Oxycodone little off," by maybe 3MI's, and tha had seen some in the sleeve. Nowas marked at the time, but the 2 night Nurse decided to note it. The relief Nurse denied the state through interviews was overheared discussing it by an NAR, (Nursing Assistant Registered.) The relief Nurse was off the next days, was called on 04/19/2021 to Director of Nursing, and was told suspended pending investigation information was obtained from set interviews that contradicted her statement, and she was terminate 04/20/2021 for not telling the trutt the incident. 	sing. on of d d a iL's of originals d we was not ift Nurse count, relief was "a t she thing ::00 a.m. ment, but two y the she was after veral ed on a about		

Facility ID: 00634

-		& MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	COMI	E SURVEY PLETED
		245339	B. WING		04/2	C 22/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
MOTHER	R OF MERCY SENIOR	LIVING				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 755	4/19/21, at 1:11 p.r report identified an neglect in which R count of her liquid medication) on 4/14 4/17/21, at 6:00 a.r observed to be thre An Opioid Medicati 4/21/21 indicated th - R1 had a physicia Oxycodone 20 mg staff to administer hours (12:00 a.m., p.m.) for pain/dysp breathing)/comfort - R1 had a physicia Oxycodone 20 mg/ administer 10 mg (as needed for pain - R2 had a physicia Morphine concentr which directed staff orally every one ho pain/dyspnea/comf R1's Oxycodone Ad dated 3/20/21 - 4/1 received as needed following: -did not receive any to 3/31/21 - 4/1/21, at 9:34 a.r	n. by the DON. The incident allegation of medication 1 had an accurate shift to shift Oxycodone (opioid pain 6/21 at 2:00 p.m.; however, on n. the Oxycodone count was be milliliters (ml) "short." Ton Report, dated 3/21/21 - he following: an order, dated 2/19/21, for (milligrams)/ml which directed 10 mg (0.5 ml) orally every six 6:00 a.m., 12:00 p.m. and 6:00 nea (difficulty care. an order, dated 2/25/21, for fml which directed staff to 0.5 ml) orally every one hour /dyspnea/comfort cares. an order, dated 10/27/20, for ate 100 mg/5 ml (20 mg/ml) f to administer 5 mg (0.25 ml) ur as needed for fort. dministration History Report, 9/21, indicated R1 had d administrations on the y administration from 3/20/21 m. by registered nurse (RN)-A m. by licensed practical nurse .m. by LPN-C	F 755	 On April 19, 2021, a "Controlle Substance Education" was giv Nurses and TMA's. (see attact The RN Managers and Directo will review the Narcotic Books All of the above were complete 04/20/2021. The Director of Nursing, Susa BSN, RN, will be responsible f and maintaining this complian 	ren to all ched). or of Nursing weekly. ed on n Roberts, for ensuring	

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY IPLETED	
		245339	B. WING				C 22/2021	
NAME OF F	PROVIDER OR SUPPLIER	L	<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
MOTHER	R OF MERCY SENIOR			2	230 CHURCH AVENUE, BOX 676			
				A	ALBANY, MN 56307			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Continued From pa p.m. by LPN-B R1's Oxycodone Ind sheets, dated 2/16/ following dosage co - 2/18/21, at 4:35 a. spilt 2.75 ml and the - 2/23/21, no docum the amount from 11 justification for dosa discrepancy was re - 3/11/21, at 5:10 a. amount from 5.5 m justification for dosa discrepancy was re - 3/11/21, at 5:30 p. amount from 1 ml to justification for dosa discrepancy was re - 3/26/21, no docum the amount from 2 p justification for dosa discrepancy was re - 3/26/21, no docum the amount from 2 p justification for dosa discrepancy was re - 4/14/21, at 4:40 p. 2.5 ml to 0 ml. Reco dosage correction, reported and invest - 4/17/21, no docum dose from 21 ml to justification for dosa discrepancy was re R1's Oxycodone Ind sheet, dated 4/14/2 amount on 4/16/21, when LPN-A and LB	age 14 dividual Narcotic Record (21 - 4/17/21, identified the prrections with a co-signer: .m. an unidentified nurse had e medication was wasted. nented time, LPN-B adjusted I ml to 8 ml. Record lacked age correction, if the sported and investigated. .m. LPN-A adjusted the I to 2 ml. Record lacked age correction, if the sported and investigated. .m. LPN-B adjusted the o 0 ml. Record lacked age correction, if the sported and investigated. .m. LPN-B adjusted the o 0 ml. Record lacked age correction, if the sported and investigated. nented time, LPN-B adjusted ml to 0 ml. Record lacked age correction, if the sported and investigated. nented time, LPN-B adjusted ml to 0 ml. Record lacked age correction, if the sported and investigated. .m. LPN-B adjusted dose from ord lacked justification for if the discrepancy was	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE	
		d Oxycodone to R1 on .m. and documented 21.5 ml						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245339	B. WING				C 22/2021
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR	LIVING			230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 755	remained. She aga R1 on 4/17/21, at 5 ml remained. Record RN-A and RN-B ide the 4/16/21 count. (8:21 a.m. LPN-A be R2's quarterly MDS had moderately imp extensive physical a enrolled in hospice dementia, hemipleg a cerebrovascular a pain, and a wedge lumbar (lower) verte indicated R2 had re needed pain medic medication having B self-reported occas day activities. R2's Morphine Adm dated 2/8/21 - 4/22/ as needed administ - 2/8/21 - 2/19/21, for multiple nurses - 3/17/21 and 3/23/2 nurses - 4/10/21, for a total R2's Morphine cond Record sheet ident Morphine 30 ml del 1/30/21 which had i 2/8/21. On 4/12/21 remained when the to be clear in color. consistent with R2's	in administered Oxycodone to (00 a.m. and documented 21 rds lacked documentation entified a discrepancy during See interview on 4/22/21, at elow) , dated 1/28/21, identified R2 paired cognition, required assist for ADL's, and was care. Diagnosis included gia (left sided weakness) after accident (stoke), low back compression fracture to the ebrae (spine). The MDS inceived scheduled and as ation with an opioid pain been administered. R1's ional pain limited her day to inistration History Report, (21, indicated R2 had received trations on the following: or a total of 10 doses by 21, two doses by multiple	F	75	5		

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		AND HUMAN SERVICES				FORM	: 06/15/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245339	B. WING	i			C / 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	OF MERCY SENIOR	LIVING			230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 755	however, the sheet	ige 16 identified two doses had been il (4/5/21; 4/10/21), not one.	F	755			
	Third floor Controlle [medication adminis Shift Audits, dated 3 column labeled Mee labeled Count is Co medications which taken if the medica All columns showed dashes. The audits or an N as directed line dated 4/16/21, and LPN-B perform Both columns for th mark in each colum entered adjacent to identified "#26 off b [LPN-A]." The audit a.m. identified LPN Change of Shift Aud indicated a check n written entry was er shift count which id supposed to be 21	ed Substance/MAR stration record] Change of 3/23/21 - 4/21/21, identified a ds and a column adjacent prrect (Y [yes]/N [no]) for directed staff to record action tion count had been incorrect. d either check marks and/or failed to show evidence of a Y by the instructions. The audit at 10:30 p.m. identified LPN-A ned a Change of Shift Audit. nat audit indicated a check nn. A hand written entry was the 4/16/21 shift count which by approx. 3ml's @ 2330 t line dated 4/17/21, at 6:30 -A and RN-A performed the dit. Both columns for that audit nark in each column. A hand ntered adjacent to the 4/17/21 entified "#26 17.5 ml ml [RN-C]."					
	stated on 4/17/21, a LPN-A approached start the shift to shir counting process, in Oxycodone packag narcotic drawer and Oxycodone count] of the bottle of medica counting. RN-A exp	around 6:00 a.m. she and the floor's medication cart to ft controlled medication n which LPN-A removed R1's jing box from the cart's d explained to RN-A "it [the was off" before she had pulled ation out of the box for blained she had contacted the					
		he observed the discrepancy more serious" being she had					

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		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245339	B. WING	i			C 22/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR	LIVING			230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	been aware of the or related to the allega been diluted. RN-A unaware of a system identifying potential shift to shift controll nurses were resport to shift count consist index of the narcotic medication was the medication's design actual count was cor- process looked for diversion as it basic medication was pre- correct. On 4/21/21, at 1:52 recorded on 3/23/21 which showed the f - 3/23/21, at 3:56 p. Morphine packagin medication cart look removed a new me bottom drawer. LPN- narcotic record boo down the hallway to taking the Morphine review for administit the hallway she plat uniform pocket with - 3:57 p.m. LPN-B e Morphine box in he lacked evidence LP (right medication, ri	angoing investigation for R2 ation of her Morphine having explained she had been mic facility auditing process for drug diversion beyond the led medication count the nsible for. RN-A stated the shift sted of reviewing the front c book to ensure every are and then going to the nated page to ensure the overall signs of potential drug cally only ensured the esent and the count was pm. facility camera footage 1 and 4/6/21 was viewed following footage: .m. LPN-B removed R2's g box from the third floor ked narcotic bin and then dication syringe from the cart's N-B documented in the kk, closed the cart, and walked owards R2's room without e bottle out of the box to ration. As LPN-B walked down ced the Morphine box in her nout having removed her hand. entered R2's room. exited R2's r	F	755			

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		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COM	E SURVEY PLETED
		245339	B. WING	i			C 22/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOTHER	R OF MERCY SENIOR	LIVING			230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 755	 4/6/21, at 6:26 p.m. Oxycodone packag medication cart lock removed a new me bottom drawer. After she placed the Oxy pocket and walked R1's room. 6:28 p.m. LPN-B e Oxycodone box not 6:29 p.m. LPN-B e third floor medicatio room and filled the different set of dining she entered, and pr adjacent to the dining - 6:35 p.m. LPN-B e returned to the medication of the returned to the medication of the entered and pr adjacent to the dining - 6:37 p.m. LPN-B e returned to the medication of the entered and pr adjacent to the dining - 6:37 p.m. LPN-B e returned to the medication of the entered and pr adjacent to the dining - 6:37 p.m. LPN-B e returned to the medication of the entered at the enterement at the enteremen	n. LPN-B removed R1's jing box from the third floor ked narcotic bin and then dication syringe from the cart's er LPN-B closed up the cart, rcodone box in her uniform down the hallway towards exited R1's room with the t observed in her hands. obtained a plastic cup from the bin cart, walked to the dining plastic cup with juice, exited a ng room exit doors then what roceeded to a bathroom ng room. exited the bathroom and	F 7	755			

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		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245339	B. WING	i			C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOTHER	R OF MERCY SENIOR	LIVING			230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 755	that evening. The A of the video she had amount of Oxycodo ADON stated intervi- with R1 on 4/16/21 for R1 to have beer doses of Oxycodon had been in addition evening. The ADON nursing staff to cou- change of shift or c they are to compare to the actual medica "considerable" disci- count, she expected on-call nurse "right knowledge of a poli- to staff on what was medication discrepa- unable to define whi discrepancy would be thinking at the time. would have expected been updated about the evening of 4/16 medication theft rec addition, the ADON systemic process in drug diversion beyo During interview on manager (RN)-B sta discrepancy were for should be poured in measured with a sy potential need for fu-	age 19 ADON stated due to the quality d been unable to verify the one LPN-B had prepared. The views from those who worked had not supported the need n administered four as needed the by LPN-B on 4/16/21 which n to her scheduled doses that N explained she expected nt controlled medications at hange in nursing staff in which e what is in the narcotic book ation on hand. If there was a repancy found during the d the nurses to contact the away." The ADON denied icy which provided information s considered a reportable ancy amount and had been hat a considerable medication consist of; however, she be "based on the nurses ." The ADON verbalized she ed the on-call nurse to have at the Oxycodone discrepancy /21 as allegations of quired reporting to the SA. In denied the facility had a n place for identifying potential ond the shift to shift count. A/21/21, at 3:26 p.m. unit ated if a liquid medication ound of a "ml or more" it nto a medication cup and vringe to ensure accuracy and urther reconciliation. RN-B three ml discrepancy would be and would rise to the level of	F 7	755			

If continuation sheet Page 20 of 24

		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245339	B. WING_				C 22/2021
NAME OF I	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR	LIVING			0 CHURCH AVENUE, BOX 676 LBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 755	Continued From par potentially needing RN-B explained she controlled medication nurse prior to clean could be document facility had a system identifying potential shift to shift count. When interviewed of stated she had adminisher in a row and the color may have she had not though there may have bee explained she had adminisher in a row and the color may have she had not though there may have bee explained she had adminisher there may have bee explained she		F 7	55		RIATE	DATE
	when she had walk the medication cart When interviewed v 6:15 p.m. LPN-B de observed and/or tal discrepancies durin	ed by them as they stood at					

If continuation sheet Page 21 of 24

		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245339	B. WING				C 22/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				2	30 CHURCH AVENUE, BOX 676		
MOTHER	R OF MERCY SENIOR	LIVING		Α	ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	Continued From pa	-	F 7	755			
	Oxycodone had spi When questioned of video footage when R2's medication in l explained she had in their medications at had when she expen- narcotic box to obta she explained she had and had not though doing. LPN-B denie Oxycodone when s on 4/6/21 and expla- medication had bee entered the bathroot During a telephone a.m. LPN-A stated so Oxycodone to be le documented amoun performed the 4/16, controlled medication had explained the m couple of ml's" in w attempted to pour th bottle after some has medication syringe LPN-B had been un acknowledged the of approximately three she continued to do based Oxycodone a	It during her shift on 4/16/21. It during her shift on 4/16/21. It during her shift on 4/6/21 e she had placed R1's and her uniform pockets, LPN-B not wanted them to wait for ny longer than they already erienced difficulty opening the ain the medications. Further, nad been distracted at times it about what she had been ed she had taken R1's he had been in the bathroom ained she had forgotten the en in her pocket when she om that evening. interview on 4/22/21, at 8:21 she had visualized R1's liquid ass than the narcotic book nt when she and LPN-B /21's evening shift to shift on count. LPN-A stated LPN-B nedication had been "off a hich LPN-B indicated she had he medication back in the ad spilt in the plastic holding sleeve; however nable to "salvage any." LPN-A Oxycodone had been off e ml's. LPN-A acknowledged ocument the correct math amount on R1's Oxycodone					
	liquid amount obset times she had adm 4/16/21 and 4/17/2 ⁻ been under the ass present to change t	Record instead of the actual rved in the bottle during the inistered R1's Oxycodone on 1 as she expressed she had umption two nurses had to be he amount in the book. LPN-A not documented the					

If continuation sheet Page 22 of 24

		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY IPLETED
		245339	B. WING	i			C 22/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	230 CHURCH AVENUE, BOX 676		
	R OF MERCY SENIOR	LIVING		A	ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 755	discrepancy with LF any other nurse wh LPN-A denied she I or facility managem evening. LPN-A cor discrepancy was re been on the mornin contacted the DON when she filled out Substance/MAR CF checked it as every any notations on th had observed the C together on 4/16/21 facility had a proces diversion beyond th further denied she I When interviewed of DON stated the free administered Oxyco "extraordinary." The investigation proces Oxycodone had spi syringe; however, th always used a "free administered liquid the camera footage during R1's investig was not suspecting been trying to figure however, she had to the investigation pro- evidence of R2's M R1's Oxycodone por and then the three had been medication facility had a proces	PN-B during the count or with o worked that shift. Further, had updated the on-call nurse nent about the discrepancy that nfirmed the first time the ported to management had ng of 4/17/21, when RN-A . In addition, LPN-A explained	F	755			

If continuation sheet Page 23 of 24

		AND HUMAN SERVICES				FORM	06/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245339	B. WING	i			C 22/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MOTHER OF MERCY SENIOR LIVING					30 CHURCH AVENUE, BOX 676 ALBANY, MN 56307		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Continued From pa	ge 23	F 7	755			
	revised 4/21/21, dir TMA's (trained med all controlled drugs a discrepancy caus Manager/DON was policy directed nurs evidence of substitu medications were b failed to identify ste facility took to decre above and beyond counting and the po	Policy and Procedure policy, ected that two nurses and/or dication aides) were to count at the end of each shift and if e could not be found the RN to be updated. Further, the esthey "must be alert for any ution or tampering" when being counted." The policy ps and/or processes the ease the risk of drug diversion general shift to shift narcotic olicy further failed to direct staff f drug diversion and how to on indicators.					

If continuation sheet Page 24 of 24



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 10, 2021

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

Re: State Nursing Home Licensing Orders Event ID: KP9H11

Dear Administrator:

The above facility was surveyed on April 21, 2021 through April 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Mother Of Mercy Senior Living May 10, 2021 Page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Susie Haben, Unit Supervisor St. Cloud B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: susie.haben@state.mn.us Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
		00634	B. WING		04/2	C 2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR		RCH AVENUE MN 56307	E, BOX 676		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found no State Licensure. Pla plan of correction you and identify the date	"S: 1, a complaint survey was acility by a surveyor from the eent of Health (MDH). Your of in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 05/20/21

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 14

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00634	B. WING	B. WING		22/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR		RCH AVENUE, MN 56307	BOX 676		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	The following complaints were found to be SUBSTANTIATED: H5339030C (MN00071838) with a licensing order issued at 0555. H5339031C (MN00072010) with licensing orders issued at 0555 and 1980. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.					
	receipt of State lice the Minnesota Depa Informational Bullet https://www.health.s n/infobulletins/ib14_ orders are delineate Department of Hea you electronically. is necessary for Sta enter the word "CO available for text. Ye	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY C	
		00634	B. WING		04/22/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR		RCH AVENUI MN 56307	E, BOX 676		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
2 000	Continued From pa	ge 2	2 000			
		and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 555	MN Rule 4658.040 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555		5/21/21	
	must develop a cor each resident within completion of the c assessment as def comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the	elopment. A nursing home nprehensive plan of care for n seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the , a registered nurse with e resident, and other disciplines as determined by s, and, to the extent e participation of the resident, guardian or chosen				
	by: Based on interview facility failed to dev comprehensive car R2) who did not ha comprehensive car 21 days following a	ent is not met as evidenced and document review, the elop a person-centered e plan for 2 of 2 residents (R1, ve a person-centered, e plan completed no later than dmission and revised to vith resident care needs.		Tag 0555: Going forward, there will be an addition column on the MDS schedule, indicatin "Date Completed" for the comprehensiv Care Plan. (See attachment).	g	
				These schedules will be reviewed and		

If continuation sheet 3 of 14

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00634		LE CONSTRUCTION		SURVEY PLETED
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	04/2	.2/2021
		230 CHU	RCH AVENU			
MOTHER	R OF MERCY SENIOR		, MN 56307	_, _ • • • • •		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	ge 3	2 555			
	R1's quarterly Minin 1/19/21, identified F 10/12/20. Further, t intact cognition, imp required limited to e activities of daily livi in hospice care. Dia heart failure (CHF), heart failure (CHF), spondylosis (neck a R1 had received sc medication with an been administered, anti-anxiety, and an medications. R1's s impacted her sleep activities, along with In addition, R1 had On 4/21/21, at 11:0 record (EMR) was n following comprehe categories: Pressure ulcer, sta - Activities, start da - Nutritional status, - Skin tear injury ris On 4/21/21, around a paper copy of R1' which identified the categories: - Pain, reviewed/rev	num Data Set (MDS), dated R1 admitted to the facility on he MDS identified R1 had paired hearing and vision, extensive physical assist with ing (ADLs), and was enrolled agnosis included congestive anxiety, diabetes, congestive morbid obesity, and arthritis). The MDS indicated heduled and as needed pain opioid pain medication having along with the use of diuretic, ticoagulant (blood thinner) self-reported frequent pain and limited her day to day n mild depression symptoms. bladder incontinence. 5 a.m. R1's electronic medical reviewed and identified the ensive care plan problem art date 11/2/20. te 1/19/21.		monitored by the Director of corrective actions will be in place 05/21/2021. Susan Roberts, BSN, RN Nursing will be responsible	aken if needed. e on or before Director of	
	4/21/21, at 12:03 p. - Hospice, reviewed p.m. - Falls, reviewed/rev					

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00634			04//	22/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST RCH AVENUE,			
MOTHEF	R OF MERCY SENIOR		, MN 56307	Box ore		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 555	rehabilitation potent transfers, toileting, dressing, bed mobi on 4/21/21, at 12:28 R1's medical record centered comprehe preference and goa address the resider mental and psychos R2's quarterly MDS admitted to the faci MDS identified R2 f cognition, impaired extensive physical a enrolled in hospice dementia, anxiety, o sided weakness) af (stoke), low back pa fracture to the lumb The MDS indicated and as needed pair pain medication hav with antidepressant self-reported occas day activities, along symptoms. In additi bowel and bladder i remnants in her mo	daily living) functional / tial for individual areas of personal hygiene, eating, lity, bathing, reviewed/revised 3 p.m. d lacked a completed person insive care plan to meet R1's ils, which were measurable to at's overall medical, physical, social needs. , dated 1/28/21, identified R2 lity on 8/27/20. Further, the head moderately impaired hearing and vision, required assist for ADL's, and was care. Diagnosis included dysphagia, hemiplegia (left ter a cerebrovascular accident ain, and a wedge compression ar (lower) vertebrae (spine). R2 had received scheduled medication with an opioid ving been administered, along medication. R1's ional pain limited her day to with mild depression on, the MDS identified R2 had ncontinence, held food/food outh after meals, and utilized				
	record (EMR) was n following comprehe categories: - Nutritional Status, - Pressure injury ris	reviewed and identified the nsive care plan problem reviewed/revised 10/29/20. k, reviewed/revised 11/12/20. l/revised on 3/18/21.				

STATE FORM

6899

KP9H11

If continuation sheet 5 of 14

ROVIDER OR SUPPLIER	00004				PLETED	
ROVIDER OR SUPPLIER	00634		B. WING		C 04/22/2021	
	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
OF MERCY SENIOR		RCH AVENUE, MN 56307	BOX 676			
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	ge 5	2 555				
a paper copy of R2' which identified the categories: - Pain, reviewed/rev - Urinary incontinen at 12:57 p.m. - ADL functional / re individual areas of v toileting, personal h mobility, bathing, re 12:57 p.m. R2's medical record centered comprehe preference and goa	's comprehensive care plan following additional problem vised on 4/21/21, at 12:44 p.m. nce, reviewed/revised 4/21/21, ehabilitation potential for walking/wheeling, transfers, nygiene, eating, dressing, bed eviewed/revised on 4/21/21, at d lacked a completed person ensive care plan to meet R2's als, which were measurable to					
During interview on assistant director of Nurse Manager for admission a resider plan was to be com admission MDS have explained she and to (RN) Managers were process was comple provide the best incorresident they could comprehensive car quarterly with the quany resident experies The ADON confirmed	4/21/21, at 2:11 p.m. the f nursing (ADON)(Registered third floor), stated after nt's initial comprehensive care pleted within 14 days after the d been due. The ADON the other Registered Nurse re responsible to ensure this leted in order for the facility to dividualized care for each . Further, she explained the e plan was to be reviewed uarterly MDS process and with enced changes in condition. ed R1's and R2's					
in to Leo Da Para La	Continued From pa Falls, reviewed/re Skin tear injury ris On 4/21/21, around a paper copy of R2 which identified the categories: Pain, reviewed/rev Urinary incontinen at 12:57 p.m. ADL functional / re ndividual areas of v oileting, personal h nobility, bathing, re 12:57 p.m. R2's medical record centered comprehe oreference and goa address the resider mental and psycho During interview on assistant director o Nurse Manager for admission a resider olan was to be com admission MDS ha explained she and RN) Managers we process was completed or provide the best ind esident they could comprehensive car quarterly with the q any resident experi The ADON confirm comprehensive car eviewed/revised da	Pain, reviewed/revised on 4/21/21, at 12:44 p.m. Urinary incontinence, reviewed/revised 4/21/21, at 12:57 p.m. ADL functional / rehabilitation potential for individual areas of walking/wheeling, transfers, oileting, personal hygiene, eating, dressing, bed nobility, bathing, reviewed/revised on 4/21/21, at 12:57 p.m. R2's medical record lacked a completed person centered comprehensive care plan to meet R2's preference and goals, which were measurable to address the resident's overall medical, physical, mental and psychosocial needs. During interview on 4/21/21, at 2:11 p.m. the assistant director of nursing (ADON)(Registered Nurse Manager for third floor), stated after admission a resident's initial comprehensive care blan was to be completed within 14 days after the admission MDS had been due. The ADON explained she and the other Registered Nurse RN) Managers were responsible to ensure this process was completed in order for the facility to provide the best individualized care for each esident they could. Further, she explained the comprehensive care plan was to be reviewed quarterly with the quarterly MDS process and with any resident experienced changes in condition. The ADON confirmed R1's and R2's comprehensive care plans, with a eviewed/revised date of 4/21/21, had been initially developed and placed in the EMR that	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Continued From page 5 2 555 Falls, reviewed/revised on 3/18/21. Skin tear injury risk, reviewed/revised 4/13/21. On 4/21/21, around 1:00 p.m. the ADON provided a paper copy of R2's comprehensive care plan which identified the following additional problem categories: Pain, reviewed/revised on 4/21/21, at 12:44 p.m. Urinary incontinence, reviewed/revised 4/21/21, at 12:57 p.m. ADL functional / rehabilitation potential for ndividual areas of walking/wheeling, transfers, oileting, personal hygiene, eating, dressing, bed mobility, bathing, reviewed/revised on 4/21/21, at 12:57 p.m. R2's medical record lacked a completed person centered comprehensive care plan to meet R2's preference and goals, which were measurable to address the resident's overall medical, physical, nental and psychosocial needs. During interview on 4/21/21, at 2:11 p.m. the assistant director of nursing (ADON)(Registered Nurse Manager for third floor), stated after admission a resident's initial comprehensive care plan was to be completed within 14 days after the admission MDS had been due. 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Skin tear injury risk, reviewed/revised 4/13/21. 2 555 On 4/21/21, around 1:00 p.m. the ADON provided paper copy of R2's comprehensive care plan vhich identified the following additional problem integories: 2 555 Pain, reviewed/revised on 4/21/21, at 12:44 p.m. Urinary incontinence, reviewed/revised 4/21/21, at 12:57 p.m. ADL functional / rehabilitation potential for ndividual areas of walking/wheeling, transfers, oileting, personal hygiene, eating, dressing, bed nobility, bathing, reviewed/revised on 4/21/21, at 12:57 p.m. R2's medical record lacked a completed person isonference and goals, which were measurable to address the resident's overall medical, physical, nental and psychosocial needs. During interview on 4/21/21, at 2:11 p.m. the assistant director of nursing (ADON)(Registered Nurse Manager for third floor), stated after admission a resident's initial comprehensive care plan was to be completed within 14 days after the admission MDS had been due. 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If continuation sheet 6 of 14

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00634	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	Сом	E SURVEY PLETED C 22/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
NOTHER	R OF MERCY SENIOR		JRCH AVENUE, ⁄, MN 56307	BUX 878		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
		· · · · ·		DEFICIEN	CY)	
2 555	Continued From pa	nge 6	2 555			
		0				
		knowledged R1 and R2's hensive care plans should				
		d at a minimum during their				
		assessment process after				
		ons and explained "time				
		I to job duties had been the				
		e incomplete comprehensive				
		nied the facility had an auditing				
		ensure comprehensive care	9			
		ted within required time				
	frames.	·				
	When interviewed of	on 4/21/21, at 3:26 p.m. RN-B				
	stated the RN Mana	agers have three weeks to				
		s comprehensive care plan				
		n. She explained she would				
		s on the care plan triggered				
		MDS process or items such				
		nents. Further, RN-B explained	b			
	she would have exp					
		e plan developed and revised				
		lents admitted in August and				
		specially since these residents	5			
		eir care plans reviewed				
		admissions. RN-B denied the ting process in place to ensure				
		e plans were completed withir				
	required time frame		•			
	A Mother of Mercv	Care Planning policy, revised				
		the facility would ensure a				
		olan of care was developed for				
		h included the resident's goals				
		rengths, assessed and				
		which identified key networks				
		ned interventions, and				
		l to treatment, wellness and				
		y directed the RN Unit				
		d a Plan of Care for each				
	resident within 21 d	lays of the admission date and	4			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00634		CONSTRUCTION	СОМ (E SURVEY PLETED C 22/2021
				22/2021		
	PROVIDER OR SUPPLIER	230 CHU	DRESS, CITY, ST RCH AVENUE,			
MOTHER	R OF MERCY SENIOR		MN 56307			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 555	Care based on the when there were c interventions identific changes in the Resident's health condition, ar after the Resident's SUGGESTED MET administrator or des policies or procedu development of residents or procedu development of residents comprehensive facility should re-edicitation to policies a residents comprehensive completion complia audits should be tal Performance Impro- determine the needic compliance.	periodic review of the Plan of Resident's individual needs hanges in goals, objectives, or fied, when warranted by ident's medical or behavioral ad must be reviewed quarterly	2 555			
21980	Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults f report. (a) A mandated	21980			4/26/21
	reporter who has revulnerable adult is lor who has knowled has sustained a phreasonably explained information to the condividual is a vulner the individual is adult	being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected				

Minnesc	ta Department of He	ealth				ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00634	B. WING		C 04/22/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	TATE, ZIP CODE		-
		230 CHU	RCH AVENUE			
MOTHER	R OF MERCY SENIOR	LIVING ALBANY,	MN 56307			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ige 8	21980			
	maltreatment of the to admission, unles	e individual that occurred prior ss:				
Minnesota D	another facility and believe the vulnera previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecte knows or has rease been made to the or (d) Nothing in thi reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must subdivision. If the time believes that a agency will determin the reported error w the criteria under se 17, paragraph (c), of facility may provide directly to the lead how the event mee 626.5572, subdivisi (5). The lead agen	s section requires a report of d maltreatment, if the reporter on to know that a report has common entry point. s section shall preclude a reporting to a law enforcement reporter who knows or has nat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ne or should determine that vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ts the criteria under section ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of				

If continuation sheet 9 of 14

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	LETED
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	04/2	2/2021
MOTHEF	R OF MERCY SENIOR		RCH AVENU MN 56307	E, BOX 676		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21980	This MN Requirem by: Based on interview facility failed to report theft to the State Age the allegation for 1 for misappropriatio Findings include: R1's quarterly Minin 1/19/21, identified F required limited to a activities of daily livi included congestive obesity, and spond MDS indicated R1 as needed pain me medication having self-reported freque and day to day acti An initial report was 4/19/21, at 1:11 p.m (DON). The incider of medication negle	ent is not met as evidenced and document review, the ort allegations of medication gency (SA) within 24 hours of of 1 residents (R1) reviewed n of property. mum Data Set (MDS), dated R1 had intact cognition and extensive physical assist with ring (ADLs). Diagnosis e heart failure (CHF), morbid ylosis (neck arthritis). The had received scheduled and edication with an opioid pain been administered. R1's ent pain impacted her sleep	21980	Tag: 1980 The error of not reporting has I corrected by the following: The Director of Nursing who su report has reviewed the Depar Health protocols and reviewed protocols with the Nurse Mana have access to report. In addition, the nurse who wait to anyone was instructed and r that she needed to report as so discrepancy was found. The Director of Nursing will mo protocols are followed in the fu This was corrected on 04/26/20 Audits of complaints and allege will be conducted through June for timeliness of reporting. Tim reporting will be reviewed at th Quality Assurance meeting tha	ubmitted the tment of the gers, who ed to report eminded oon as a onitor that all ture. 021. ed abuse e 15, 2021 hely e next	
	(opioid pain medica however, on 4/17/2 count was observe "short." Further, the received her Oxyco R1 had been noted During interview on registered nurse (R around 6:00 a.m. s nurse (LPN)-A app cart to start the shift	ation) on 4/16/21 at 2:00 p.m.; 1, at 6:00 a.m. the Oxycodone d to be three milliliters (ml) e report identified R1 had odone doses and no injury to		scheduled for June 15, 2021. Paul Gaebe, Administrator, wil responsible that the Director of ensures that the reporting is co within 24 hours.	l be ⁻ Nursing	

If continuation sheet 10 of 14

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00634	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/22/2021	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	R OF MERCY SENIOR	230 CHU	RCH AVENUE,			
		ALBANY	, MN 56307			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ige 10	21980			
C n C ti f c ti d b ir c o f c u a d ti	Oxycodone packaging box from the cart's narcotic drawer and explained to RN-A "it [the Oxycodone count] was off" before she had pulled the bottle of medication out of the packaging box for counting. RN-A explained she had contacted the DON shortly after she observed the discrepancy as she had "took it more serious" being she had been aware of an ongoing investigation at that time related to an allegation of diluted liquid Morphine (opioid pain medication) for a different resident. RN-A stated she was to update a manager or the on-call nurse "right away" if she were to find a controlled medication discrepancy as they had time frames for when they needed to report allegations of medication theft to the SA.					
	assistant director of expected the nurse "right away" when a discrepancy had be knowledge of a polit to staff on what was medication discrepa unable to define wh discrepancy would explained it would be thinking at the time would have expected been updated about the evening of 4/16	on 4/21/21, at 2:11 p.m. the f nursing (ADON) stated she is to contact the on-call nurse a "considerable" medication een found. The ADON denied icy which provided information s considered a reportable ancy amount and had been nat a considerable medication consist of; however, she be "based on the nurses ." The ADON verbalized she ed the on-call nurse to have at the Oxycodone discrepancy /21 as allegations of quired reporting to the SA the allegation.				
	manager (RN)-B st discrepancy were for should be poured in	4/21/21, at 3:26 p.m. unit ated if a liquid medication ound of a "ml or more" it nto a medication cup and yringe to ensure accuracy and				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00634		B. WING		C 04/22/2021	
					04/	22/2021	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, S				
MOTHER	OF MERCY SENIOR		URCH AVENUE	, BOX 676			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21980	Continued From pa	age 11	21980				
	explained a two or "concerning" to her	urther reconciliation. RN-B three ml discrepancy would b r and would rise to the level o to be reported to the SA "in ."					
	5:56 p.m. nursing a evening of 4/16/21 LPN-A "the oxy wa	via telephone on 4/21/21, at assistant (NA)-A stated on the she had overheard LPN-B te s off by a bit" when she had they stood at the medication					
	a.m. LPN-A stated Oxycodone to be le documented amou performed the 4/16 controlled medicati stated LPN-B had been "off a couple indicated she had a medication back in in the plastic medic however LPN-B had any." LPN-A ackno been off approxima explained she had with LPN-B and had to any of the other on-call nurse, or fa confirmed the first reported to manag morning of 4/17/21 DON after that more	a telephone on 4/22/21, at 8:2 she had visualized R1's liquid ess than the narcotic book int when she and LPN-B 5/21's evening shift to shift ion counting process. LPN-A explained the medication had of mI's" in which LPN-B attempted to pour the the bottle after some had spi cation syringe holding sleeve; id been unable to "salvage wledged the Oxycodone had ately three mI's. LPN-A not followed up more on this id not reported the discrepance nurses working that shift, the cility management. LPN-A time the discrepancy was ement had been on the when RN-A contacted the rning's shift to shift count. ged having been trained on	ilt				
	abuse which includ explained abuse w	led medication theft and as to be reported within a purs to her supervisor.					

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00634				04/22/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MOTHER	R OF MERCY SENIOR		RCH AVENUE, , MN 56307	BOX 676		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLET DATE
21980	Continued From page 12		21980			
	When interviewed on 4/22/21, at 9:11 a.m. the DON stated at the time of her being notified of					
	R1's medication discrepancy she had not					
	"necessarily" suspected theft and she had wished					
	to further investigate the situation to determine what had occurred, such as spillage, which would					
	have not been a reportable situation. The DON					
	explained she understood timelines for SA					
	reporting of medication theft allegations and that she should have reported R1's medication					
	discrepancy to the	•				
	An Abuse Prevention and Vulnerable Adult					
	Procedure policy, dated 10/18/19, indicated one					
	of its intents was to provide guidelines for investigating and reporting of suspected					
	maltreatment. Maltreatment was defined to					
	include abuse, neglect, financial exploitation, and					
	misappropriate of property in which					
		resident property/financial d resident medications. The				
	•	uspected abuse, neglect,				
	and/or maltreatmer	nt to be reported promptly in				
		he report must be made				
	whether the abuse	later than two hours to the SA and/or neglect was				
		t. Further, the policy directs				
		bt be sure to report," and that				
	the administrator is	to be notified immediately.				
		HOD OF CORRECTION: The				
		signee could develop/revise				
		res to ensure timely reporting drug diversion by nursing				
		ould re-educate staff identified				
	in the citation to pol	licies and procedures, and				
		of alleged abuse or neglect				
		d time. The results of those ken to the Quality Assurance				
		ovement (QAPI) committee to				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
00634		IDENTIFICATION NOMBER.	A. BUILDING: B. WING		C 04/22/2021	
		00634				
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OTHER	R OF MERCY SENIOR		JRCH AVENUE, (, MN 56307	, BOX 676		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLET
			TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
21980	Continued From page 13		21980			
	determine the need for further monitoring or compliance.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					