DEPARTMENT OF HEALTH

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.

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

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.

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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 04/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/21/21 - 4/22/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5339030C (MN00071838), with deficiencies cited at F656 and F755. H5339031C (MN00072010), with deficiencies cited at F609, F656, and F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		4/26/21

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

Electronically Signed | 05/20/2021

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F 609	Continued From page 1 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of medication theft to the State Agency (SA) within 24 hours of the allegation for 1 of 1 residents (R1) reviewed for misappropriation of property. Findings include: R1's quarterly Minimum Data Set (MDS), dated 1/19/21, identified R1 had intact cognition and required limited to extensive physical assist with activities of daily living (ADLs). Diagnosis included congestive heart failure (CHF), morbid obesity, and spondylosis (neck arthritis). The MDS indicated R1 had received scheduled and as needed pain medication with an opioid pain medication having been administered. R1's self-reported frequent pain impacted her sleep	F 609	F - 609 The error of not reporting has been corrected by the following: The Director of Nursing who submitted the report has reviewed the Department of Health protocols and reviewed the protocols with the Nurse Managers, who have access to report. In addition, the nurse who waited to report to anyone was instructed and reminded that she needed to report as soon as a discrepancy was found. The Director of Nursing will monitor that all protocols are followed in the future.	

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F 609	Continued From page 2 and day to day activities. An initial report was submitted to the SA on 4/19/21, at 1:11 p.m. by the director of nursing (DON). The incident report identified an allegation of medication neglect in which R1 had an accurate reconciliation of her liquid Oxycodone (opioid pain medication) on 4/16/21 at 2:00 p.m.; however, on 4/17/21, at 6:00 a.m. the Oxycodone count was observed to be three milliliters (ml) "short." Further, the report identified R1 had received her Oxycodone doses and no injury to R1 had been noted. During interview on 4/21/21, at 12:38 p.m. registered nurse (RN)-A stated on 4/17/21, around 6:00 a.m. she and licensed practical nurse (LPN)-A approached the floor's medication cart to start the shift to shift controlled medication counting process, in which LPN-A removed R1's 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. When interviewed on 4/21/21, at 2:11 p.m. the assistant director of nursing (ADON) stated she	F 609	This was corrected on 04/26/2021. Paul Gaebe, Administrator, will be responsible that the Director of Nursing ensures that the reporting is completed within 24 hours.	

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F 609	Continued From page 3	F 609		

expected the nurses to contact the on-call nurse "right away" when a "considerable" medication discrepancy had been found. The ADON denied knowledge of a policy which provided information to staff on what was considered a reportable medication discrepancy amount and had been unable to define what a considerable medication discrepancy would consist of; however, she explained it would be "based on the nurses thinking at the time." The ADON verbalized she would have expected the on-call nurse to have been updated about the Oxycodone discrepancy the evening of 4/16/21 as allegations of medication theft required reporting to the SA within two hours of the allegation.

During interview on 4/21/21, at 3:26 p.m. unit manager (RN)-B stated if a liquid medication discrepancy were found of a "ml or more" it should be poured into a medication cup and measured with a syringe to ensure accuracy and potential need for further reconciliation. RN-B explained a two or three ml discrepancy would be "concerning" to her and would rise to the level of potentially needing to be reported to the SA "in less than 24 hours."

When interviewed via telephone on 4/21/21, at 5:56 p.m. nursing assistant (NA)-A stated on the evening of 4/16/21 she had overheard LPN-B tell LPN-A "the oxy was off by a bit" when she had walked by them as they stood at the medication cart.

During interview via telephone on 4/22/21, at 8:21 a.m. LPN-A stated she had visualized R1's liquid Oxycodone to be less than the narcotic book documented amount when she and LPN-B performed the 4/16/21's evening shift to shift

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F 609	Continued From page 4	F 609		

controlled medication counting process. LPN-A stated LPN-B had explained the medication had been "off a couple of ml's" in which LPN-B indicated she had attempted to pour the medication back in the bottle after some had spilt in the plastic medication syringe holding sleeve; however LPN-B had been unable to "salvage any." LPN-A acknowledged the Oxycodone had been off approximately three ml's. LPN-A explained she had not followed up more on this with LPN-B and had not reported the discrepancy to any of the other nurses working that shift, the on-call nurse, or facility management. LPN-A confirmed the first time the discrepancy was reported to management had been on the morning of 4/17/21 when RN-A contacted the DON after that morning's shift to shift count. LPN-A acknowledged having been trained on abuse which included medication theft and explained abuse was to be reported within a minimum of two hours to her supervisor.

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 SA prior to 4/19/21.

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

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F 609	Continued From page 5 include abuse, neglect, financial exploitation, and misappropriate of property in which misappropriation of resident property/financial exploitation included resident medications. The policy directed all suspected abuse, neglect, and/or maltreatment to be reported promptly in which an initial online report must be made immediately but no later than two hours to the SA whether the abuse and/or neglect was substantiated or not. Further, the policy directs staff, "When in doubt be sure to report," and that the administrator is to be notified immediately.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		5/21/21

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F 656	Continued From page 6 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a person-centered comprehensive care plan for 2 of 2 residents (R1, R2) who did not have a person-centered, comprehensive care plan completed no later than 21 days following admission and revised to remain consistent with resident care needs. R1's quarterly Minimum Data Set (MDS), dated 1/19/21, identified R1 admitted to the facility on 10/12/20. Further, the MDS identified R1 had intact cognition, impaired hearing and vision, required limited to extensive physical assist with activities of daily living (ADLs), and was enrolled in hospice care. Diagnosis included congestive heart failure (CHF), anxiety, diabetes, congestive heart failure (CHF), morbid obesity, and spondylosis (neck arthritis). The MDS indicated R1 had received scheduled and as needed pain medication with an opioid pain medication having	F 656	F: 656 Correction for F656 -second submission 6/9/2021 Resident 1 had no apparent ill effects from the suspected dilution or discrepancy in count, including any increased pain, she was and still remains on hospice. Has scheduled oxycodone, rarely takes prn. Resident 2 had no apparent ill effects from the suspected dilution of her morphine, it is prn and she does not take very often ask for it, during the time of the diluting, and ongoing. Both residents 1 and 2 had a completed RIS care plan (Resident Instruction sheet) that the aides use, and all needs were met. In addition, both resident□s needs	

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F 656	Continued From page 7 been administered, along with the use of diuretic, anti-anxiety, and anticoagulant (blood thinner) medications. R1's self-reported frequent pain impacted her sleep and limited her day to day activities, along with mild depression symptoms. In addition, R1 had bladder incontinence. On 4/21/21, at 11:05 a.m. R1's electronic medical record (EMR) was reviewed and identified the following comprehensive care plan problem categories: - Pressure ulcer, start date 11/2/20. - Activities, start date 1/19/21. - Nutritional status, start date 2/2/21. - Skin tear injury risk, reviewed/revised on 4/7/21. On 4/21/21, around 1:00 p.m. the ADON provided a paper copy of R1's comprehensive care plan which identified the following additional problem categories: - Pain, reviewed/revised on 4/21/21, at 11:50 a.m. - Adaptive Equipment, reviewed/revised on 4/21/21, at 12:03 p.m. - Hospice, reviewed/revised on 4/21/21, at 12:07 p.m. - Falls, reviewed/revised on 4/21/21, at 12:11 p.m. - Urinary incontinence, reviewed/revised 4/21/21, at 12:28 p.m. - ADL (activities of daily living) functional / rehabilitation potential for individual areas of transfers, toileting, personal hygiene, eating, dressing, bed mobility, bathing, reviewed/revised on 4/21/21, at 12:28 p.m. R1's medical record lacked a completed person centered comprehensive care plan to meet R1's preference and goals, which were measurable to address the resident's overall medical, physical, mental and psychosocial needs.	F 656	were met in relation to the late completion of the full care plan, medications, assessments, and reported on shift to shift with any issues or changes. The full care plans are completed by the RN managers on each unit. They are fully trained in the MDS process. Each of the managers was given cc of the RAI OBRA summary of required due dates for completion of care plans to review. (cc attached labeled F-656 RAI) In order to better track compliance with timely completion of care plans, a column has been added to MDS schedule with a place to put in date completed . This will be audited weekly by the DON for 2 months, and then spot checked if all in compliance. (previously attached) All of above in place as of 5/21/2021 Compliance will be monitored by Susan M Roberts BSN, RN, DON Going forward, there will be an additional column on the MDS schedule, indicating "Date Completed" for the comprehensive Care Plan. (See attachment). These schedules will be reviewed and monitored by the Director of Nursing and corrective actions will be taken if needed. This system will be in place on or before 05/21/2021. Susan Roberts, BSN, RN Director of	

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F 656	Continued From page 8 R2's quarterly MDS, dated 1/28/21, identified R2 admitted to the facility on 8/27/20. Further, the MDS identified R2 had moderately impaired cognition, impaired hearing and vision, required extensive physical assist for ADL's, and was enrolled in hospice care. Diagnosis included dementia, anxiety, dysphagia, hemiplegia (left sided weakness) after a cerebrovascular accident (stoke), low back pain, and a wedge compression fracture to the lumbar (lower) vertebrae (spine). The MDS indicated R2 had received scheduled and as needed pain medication with an opioid pain medication having been administered, along with antidepressant medication. R1's self-reported occasional pain limited her day to day activities, along with mild depression symptoms. In addition, the MDS identified R2 had bowel and bladder incontinence, held food/food remnants in her mouth after meals, and utilized bed and chair alarms. On 4/21/21, at 11:31 a.m. R2's electronic medical record (EMR) was reviewed and identified the following comprehensive care plan problem categories: - Nutritional Status, reviewed/revised 10/29/20. - Pressure injury risk, reviewed/revised 11/12/20. - Hospice, reviewed/revised on 3/18/21. - 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.	F 656	Nursing will be responsible.	

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- ADL functional / rehabilitation potential for individual areas of walking/wheeling, transfers, toileting, 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, 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 plan 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 resident 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 reviewed/revised date of 4/21/21, had been initially developed and placed in the EMR that day. The ADON acknowledged R1 and R2's incomplete comprehensive care plans should have been identified at a minimum during their first quarterly MDS assessment process after their initial admissions and explained "time constraints" related to job duties had been the main reason for the incomplete comprehensive care plans. She denied the facility had an auditing process in place to ensure comprehensive care

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plans were completed within required time frames.

When interviewed on 4/21/21, at 3:26 p.m. RN-B stated the RN Managers have three weeks to develop a resident's comprehensive care plan after their admission. She explained she would expect to see items on the care plan triggered from the admission MDS process or items such as resident impairments. Further, RN-B explained she would have expected to see a comprehensive care plan developed and revised as needed for residents admitted in August and October of 2020, especially since these residents should have had their care plans reviewed quarterly after their admissions. RN-B denied the facility had an auditing process in place to ensure comprehensive care plans were completed within required time frames.

A Mother of Mercy Care Planning policy, revised 11/2017, identified the facility would ensure a resident-centered plan of care was developed for each resident which included the resident's goals, preferences and strengths, assessed and expressed needs, which identified key networks and supports, planned interventions, and timeframe's related to treatment, wellness and recovery. The policy directed the RN Unit Manager completed a Plan of Care for each resident within 21 days of the admission date and they would ensure periodic review of the Plan of Care based on the Resident's individual needs when there were changes in goals, objectives, or interventions identified, when warranted by changes in the Resident's medical or behavioral health condition, and must be reviewed quarterly after the Resident's admission.

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F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing staff followed acceptable standards of practice for the	F 755	F:755 There were 2 medication issues brought	4/22/21

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F 755	Continued From page 12 administration of narcotic medication and/or controlled substances (medications regulated and classified by the Drug Enforcement Agency (DEA) in a manner to prevent potential drug diversion for 2 of 2 residents (R1, R2) reviewed for misappropriation of property. In addition, the facility failed to have a systematized oversight process in place to identify discrepancies and unusual patterns related to narcotic and controlled medication administration, reconciliation, and documentation practices. Findings include: R1's quarterly Minimum Data Set (MDS), dated 1/19/21, identified R1 had intact cognition, required limited to extensive physical assist with activities of daily living (ADLs), and was enrolled in hospice care. Diagnosis included congestive heart failure (CHF), morbid obesity, and spondylosis (neck arthritis). The MDS indicated R1 had received scheduled and as needed pain medication with an opioid pain medication having been administered. R1's self-reported frequent pain impacted her sleep and limited her day to day activities. An initial report was submitted to the State Agency (SA) on 4/13/21, at 2:43 p.m. by the director of nursing (DON). The incident report identified an allegation of medication neglect and financial exploitation (medication theft) in which R2's liquid Morphine (opioid pain medication) was suspected to have been diluted in order for someone to "steal" it. The report indicated Morphine "should have been pink" in color; however, R2's Morphine had been "clear." Another initial report was submitted to the SA on	F 755	to the attention of the Director of Nursing and the Assistant Director of Nursing. The first was a suspicion of dilution of liquid Morphine and possibly liquid Oxycodone. The second involved a discrepancy of approximately 3 mL's of the same liquid Oxycodone. The originals had been replaced previously, and we were told by Pharmacy that there was not any way to check potency. The second event was a relief shift Nurse and a night Nurse were doing the count, the night Nurse reported that the relief Nurse stated that the Oxycodone was "a little off," by maybe 3Ml's, and that she had seen some in the sleeve. Nothing was marked at the time, but the 2:00 a.m. night Nurse decided to note it. The relief Nurse denied the statement, but through interviews was overheard discussing it by an NAR, (Nursing Assistant Registered.) The relief Nurse was off the next two days, was called on 04/19/2021 by the Director of Nursing, and was told she was suspended pending investigation, after information was obtained from several interviews that contradicted her statement, and she was terminated on 04/20/2021 for not telling the truth about the incident. The night Nurse involved has been re-educated about immediate documentation of any discrepancy.	

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F 755	Continued From page 13 4/19/21, at 1:11 p.m. by the DON. The incident report identified an allegation of medication neglect in which R1 had an accurate shift to shift count of her liquid Oxycodone (opioid pain medication) on 4/16/21 at 2:00 p.m.; however, on 4/17/21, at 6:00 a.m. the Oxycodone count was observed to be three milliliters (ml) "short." An Opioid Medication Report, dated 3/21/21 - 4/21/21 indicated the following: - R1 had a physician order, dated 2/19/21, for Oxycodone 20 mg (milligrams)/ml which directed staff to administer 10 mg (0.5 ml) orally every six hours (12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m.) for pain/dyspnea (difficulty breathing)/comfort care. - R1 had a physician order, dated 2/25/21, for Oxycodone 20 mg/ml which directed staff to administer 10 mg (0.5 ml) orally every one hour as needed for pain/dyspnea/comfort cares. - R2 had a physician order, dated 10/27/20, for Morphine concentrate 100 mg/5 ml (20 mg/ml) which directed staff to administer 5 mg (0.25 ml) orally every one hour as needed for pain/dyspnea/comfort. R1's Oxycodone Administration History Report, dated 3/20/21 - 4/19/21, indicated R1 had received as needed administrations on the following: -did not receive any administration from 3/20/21 to 3/31/21 - 4/1/21, at 9:34 a.m. by registered nurse (RN)-A - 4/6/21, at 6:38 p.m. by licensed practical nurse (LPN)-B - 4/10/21, at 4:41 a.m. by LPN-C - 4/14/21, at 9:05 p.m. by LPN-B - 4/15/21, at 9:38 p.m. by LPN-B - 4/16/21, at 3:24 p.m., 4:47 p.m, 9:04 p.m., 10:12	F 755	On April 19, 2021, a "Controlled Substance Education" was given to all Nurses and TMA's. (see attached). The RN Managers and Director of Nursing will review the Narcotic Books weekly. All of the above were completed on 04/20/2021. The Director of Nursing, Susan Roberts, BSN, RN, will be responsible for ensuring and maintaining this compliance.	

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F 755	Continued From page 14 p.m. by LPN-B R1's Oxycodone Individual Narcotic Record sheets, dated 2/16/21 - 4/17/21, identified the following dosage corrections with a co-signer: - 2/18/21, at 4:35 a.m. an unidentified nurse had spilt 2.75 ml and the medication was wasted. - 2/23/21, no documented time, LPN-B adjusted the amount from 11 ml to 8 ml. Record lacked justification for dosage correction, if the discrepancy was reported and investigated. - 3/11/21, at 5:10 a.m. LPN-A adjusted the amount from 5.5 ml to 2 ml. Record lacked justification for dosage correction, if the discrepancy was reported and investigated. - 3/11/21, at 5:30 p.m. LPN-B adjusted the amount from 1 ml to 0 ml. Record lacked justification for dosage correction, if the discrepancy was reported and investigated. - 3/26/21, no documented time, LPN-B adjusted the amount from 2 ml to 0 ml. Record lacked justification for dosage correction, if the discrepancy was reported and investigated. - 4/14/21, at 4:40 p.m. LPN-B adjusted dose from 2.5 ml to 0 ml. Record lacked justification for dosage correction, if the discrepancy was reported and investigated. - 4/17/21, no documented time, RN-A adjusted dose from 21 ml to 17.5 ml. Record lacked justification for dosage correction, if the discrepancy was reported and investigated. R1's Oxycodone Individual Narcotic Record sheet, dated 4/14/21, identified the dosage amount on 4/16/21, at 10:10 p.m. had been 22 ml when LPN-A and LPN-B performed the shift to shift count that evening. The sheet identified LPN-A administered Oxycodone to R1 on 4/16/21, at 11:10 p.m. and documented 21.5 ml	F 755		

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remained. She again administered Oxycodone to R1 on 4/17/21, at 5:00 a.m. and documented 21 ml remained. Records lacked documentation RN-A and RN-B identified a discrepancy during the 4/16/21 count. (See interview on 4/22/21, at 8:21 a.m. LPN-A below)

R2's quarterly MDS, dated 1/28/21, identified R2 had moderately impaired cognition, required extensive physical assist for ADL's, and was enrolled in hospice care. Diagnosis included dementia, hemiplegia (left sided weakness) after a cerebrovascular accident (stoke), low back pain, and a wedge compression fracture to the lumbar (lower) vertebrae (spine). The MDS indicated R2 had received scheduled and as needed pain medication with an opioid pain medication having been administered. R1's self-reported occasional pain limited her day to day activities.

R2's Morphine Administration History Report, dated 2/8/21 - 4/22/21, indicated R2 had received as needed administrations on the following:
- 2/8/21 - 2/19/21, for a total of 10 doses by multiple nurses
- 3/17/21 and 3/23/21, two doses by multiple nurses
- 4/10/21, for a total of one dose.

R2's Morphine concentrate Individual Narcotic Record sheet identified R2 had a new bottle of Morphine 30 ml delivered from the pharmacy on 1/30/21 which had its first dose removed on 2/8/21. On 4/12/21, at 4:56 p.m., 26.25 ml had remained when the Morphine had been observed to be clear in color. The sheet had been consistent with R2's Administration History Report for administered doses in February and March;

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however, the sheet identified two doses had been administered in April (4/5/21; 4/10/21), not one.

Third floor Controlled Substance/MAR [medication administration record] Change of Shift Audits, dated 3/23/21 - 4/21/21, identified a column labeled Meds and a column adjacent labeled Count is Correct (Y [yes]/N [no]) for medications which directed staff to record action taken if the medication count had been incorrect. All columns showed either check marks and/or dashes. The audits failed to show evidence of a Y or an N as directed by the instructions. The audit line dated 4/16/21, at 10:30 p.m. identified LPN-A and LPN-B performed a Change of Shift Audit. Both columns for that audit indicated a check mark in each column. A hand written entry was entered adjacent to the 4/16/21 shift count which identified "#26 off by approx. 3ml's @ 2330 [LPN-A]." The audit line dated 4/17/21, at 6:30 a.m. identified LPN-A and RN-A performed the Change of Shift Audit. Both columns for that audit indicated a check mark in each column. A hand written entry was entered adjacent to the 4/17/21 shift count which identified "#26 17.5 ml supposed to be 21 ml [RN-C]."

During interview on 4/21/21, at 12:38 p.m. RN-A stated on 4/17/21, around 6:00 a.m. she and LPN-A approached the floor's medication cart to start the shift to shift controlled medication counting process, in which LPN-A removed R1's 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 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

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been aware of the ongoing investigation for R2 related to the allegation of her Morphine having been diluted. RN-A explained she had been unaware of a systemic facility auditing process for identifying potential drug diversion beyond the shift to shift controlled medication count the nurses were responsible for. RN-A stated the shift to shift count consisted of reviewing the front index of the narcotic book to ensure every medication was there and then going to the medication's designated page to ensure the actual count was correct. RN-A denied the process looked for overall signs of potential drug diversion as it basically only ensured the medication was present and the count was correct.

On 4/21/21, at 1:52 pm. facility camera footage recorded on 3/23/21 and 4/6/21 was viewed which showed the following footage:
- 3/23/21, at 3:56 p.m. LPN-B removed R2's Morphine packaging box from the third floor medication cart locked narcotic bin and then removed a new medication syringe from the cart's bottom drawer. LPN-B documented in the narcotic record book, closed the cart, and walked down the hallway towards R2's room without taking the Morphine bottle out of the box to review for administration. As LPN-B walked down the hallway she placed the Morphine box in her uniform pocket without having removed her hand.
- 3:57 p.m. LPN-B entered R2's room.
- 4:01 p.m. LPN-B exited R2's room with the Morphine box in her hand. The video footage lacked evidence LPN-B followed the "7 Rights" (right medication, right dose, right resident, right route, right time, right documentation, right reason) of medication administration.

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- 4/6/21, at 6:26 p.m. LPN-B removed R1's Oxycodone packaging box from the third floor medication cart locked narcotic bin and then removed a new medication syringe from the cart's bottom drawer. After LPN-B closed up the cart, she placed the Oxycodone box in her uniform pocket and walked down the hallway towards R1's room.
- 6:28 p.m. LPN-B exited R1's room with the Oxycodone box not observed in her hands.
- 6:29 p.m. LPN-B obtained a plastic cup from the third floor medication cart, walked to the dining room and filled the plastic cup with juice, exited a different set of dining room exit doors then what she entered, and proceeded to a bathroom adjacent to the dining room.
- 6:35 p.m. LPN-B exited the bathroom and returned to the medication cart.
- 6:37 p.m. LPN-B removed the Oxycodone bottle from her left lower top uniform pocket and the Oxycodone box from her right uniform pants pocket.

When interviewed on 4/21/21, at 2:11 p.m. the assistant director of nursing (ADON) stated she started to watch facility camera footage after R2's suspected Morphine dilution. The ADON explained she had not observed concerns with R2's Morphine administration on 4/5/21 or 4/10/21 by LPN-E; however, she had concerns with the video from 3/23/21 which pertained to LPN-B. Further, the ADON explained she had not observed concerns related to R1's Oxycodone other than the 4/6/21 video which also pertained to LPN-B. In addition, camera footage was reviewed from 4/16/21 which showed LPN-B had used a new syringe each time she drew up R1's Oxycodone at the medication cart and that LPN-B had not been observed to spill the Oxycodone

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that evening. The ADON stated due to the quality of the video she had been unable to verify the amount of Oxycodone LPN-B had prepared. The ADON stated interviews from those who worked with R1 on 4/16/21 had not supported the need for R1 to have been administered four as needed doses of Oxycodone by LPN-B on 4/16/21 which had been in addition to her scheduled doses that evening. The ADON explained she expected nursing staff to count controlled medications at change of shift or change in nursing staff in which they are to compare what is in the narcotic book to the actual medication on hand. If there was a "considerable" discrepancy found during the count, she expected the nurses to contact the on-call nurse "right away." The ADON denied knowledge of a policy which provided information to staff on what was considered a reportable medication discrepancy amount and had been unable to define what a considerable medication discrepancy would consist of; however, she explained it would be "based on the nurses thinking at the time." The ADON verbalized she would have expected the on-call nurse to have been updated about the Oxycodone discrepancy the evening of 4/16/21 as allegations of medication theft required reporting to the SA. In addition, the ADON denied the facility had a systemic process in place for identifying potential drug diversion beyond the shift to shift count.

During interview on 4/21/21, at 3:26 p.m. unit manager (RN)-B stated if a liquid medication discrepancy were found of a "ml or more" it should be poured into a medication cup and measured with a syringe to ensure accuracy and potential need for further reconciliation. RN-B explained a two or three ml discrepancy would be "concerning" to her and would rise to the level of

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	245339	A. BUILDING _____ B. WING _____	C 04/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 20	F 755		

potentially needing to be reported to the SA. RN-B explained she expected if staff spilt a controlled medication they should alert another nurse prior to cleaning the spill up so that the spill could be documented properly. RN-B denied the facility had a systemic process in place for identifying potential drug diversion beyond the shift to shift count.

When interviewed on 4/21/21, at 4:03 p.m. LPN-E stated she had administered R2's Morphine two nights in a row and explained on the second night the color may have been a little lighter; however, she had not thought anything of it as she thought there may have been "separation." LPN-E explained she had been more concerned with the Morphine color during her administrations after LPN-C found the medication to be clear on 4/12/21. LPN-E stated on 4/16/21 she had observed LPN-B preparing R1's Oxycodone and questioned LPN-B on R1's pain status. At the time, LPN-B had indicated R2 had pain; however, LPN-E explained LPN-B had not alerted her of R2's pain status and the need for as needed pain medication as was her normal process when they worked together.

During a telephone interview on 4/21/21, at 5:56 p.m. nursing assistant (NA)-A stated on the evening of 4/16/21 she had overheard LPN-B tell LPN-A "the oxy [Oxycodone] was off by a bit" when she had walked by them as they stood at the medication cart.

When interviewed via telephone on 4/21/21, at 6:15 p.m. LPN-B denied she and LPN-A had observed and/or talked about any medication discrepancies during the shift to shift count on the evening of 4/16/21. Further, LPN-B denied R1's

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Oxycodone had spilt during her shift on 4/16/21. When questioned on the 3/23/21 and 4/6/21 video footage where she had placed R1's and R2's medication in her uniform pockets, LPN-B explained she had not wanted them to wait for their medications any longer than they already had when she experienced difficulty opening the narcotic box to obtain the medications. Further, she explained she had been distracted at times and had not thought about what she had been doing. LPN-B denied she had taken R1's Oxycodone when she had been in the bathroom on 4/6/21 and explained she had forgotten the medication had been in her pocket when she entered the bathroom that evening.

During a telephone interview on 4/22/21, at 8:21 a.m. LPN-A stated she had visualized R1's liquid Oxycodone to be less than the narcotic book documented amount when she and LPN-B performed the 4/16/21's evening shift to shift controlled medication count. LPN-A stated LPN-B had explained the medication had been "off a couple of ml's" in which LPN-B indicated she had attempted to pour the medication back in the bottle after some had spilt in the plastic medication syringe holding sleeve; however LPN-B had been unable to "salvage any." LPN-A acknowledged the Oxycodone had been off approximately three ml's. LPN-A acknowledged she continued to document the correct math based Oxycodone amount on R1's Oxycodone Individual Narcotic Record instead of the actual liquid amount observed in the bottle during the times she had administered R1's Oxycodone on 4/16/21 and 4/17/21 as she expressed she had been under the assumption two nurses had to be present to change the amount in the book. LPN-A explained she had not documented the

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F 755	Continued From page 22	F 755		

discrepancy with LPN-B during the count or with any other nurse who worked that shift. Further, LPN-A denied she had updated the on-call nurse or facility management about the discrepancy that evening. LPN-A confirmed the first time the discrepancy was reported to management had been on the morning of 4/17/21, when RN-A contacted the DON. In addition, LPN-A explained when she filled out the Controlled Substance/MAR Change of Shift Audits she "just checked it as everyone else" and did not make any notations on the form when she and LPN-B had observed the Oxycodone discrepancy together on 4/16/21. LPN-A denied knowledge the facility had a process for identifying potential drug diversion beyond the shift to shift count and further denied she had stolen R1's Oxycodone.

When interviewed on 4/22/21, at 9:11 a.m. the DON stated the frequency at which R1 had been administered Oxycodone on 4/16/21 had been "extraordinary." The DON explained during the investigation process LPN-B had mentioned R1's Oxycodone had spilt in the packet from the syringe; however, the DON stated LPN-B had always used a "fresh syringe" when she administered liquid medications to R1 based on the camera footage watched. The DON explained during R1's investigation she "at that moment was not suspecting theft necessarily" and had just been trying to figure out what had happened; however, she had become more concerned as the investigation progressed which supported evidence of R2's Morphine having been diluted, R1's Oxycodone possibly having been diluted, and then the three ml discrepancy which likely had been medication theft. The DON denied the facility had a process for identifying potential drug diversion beyond the shift to shift count.

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F 755	Continued From page 23 A Controlled Drug Policy and Procedure policy, revised 4/21/21, directed that two nurses and/or TMA's (trained medication aides) were to count all controlled drugs at the end of each shift and if a discrepancy cause could not be found the RN Manager/DON was to be updated. Further, the policy directed nurses they "must be alert for any evidence of substitution or tampering" when medications were being counted." The policy failed to identify steps and/or processes the facility took to decrease the risk of drug diversion above and beyond general shift to shift narcotic counting and the policy further failed to direct staff on potential signs of drug diversion and how to identify drug diversion indicators.	F 755		

DEPARTMENT OF HEALTH

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. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00634	A. BUILDING: _____ B. WING _____	C 04/22/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/21/21 - 4/22/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a person-centered comprehensive care plan for 2 of 2 residents (R1, R2) who did not have a person-centered, comprehensive care plan completed no later than 21 days following admission and revised to remain consistent with resident care needs.	2 555	Tag 0555: Going forward, there will be an additional column on the MDS schedule, indicating "Date Completed" for the comprehensive Care Plan. (See attachment). These schedules will be reviewed and	5/21/21

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2 555	Continued From page 3 R1's quarterly Minimum Data Set (MDS), dated 1/19/21, identified R1 admitted to the facility on 10/12/20. Further, the MDS identified R1 had intact cognition, impaired hearing and vision, required limited to extensive physical assist with activities of daily living (ADLs), and was enrolled in hospice care. Diagnosis included congestive heart failure (CHF), anxiety, diabetes, congestive heart failure (CHF), morbid obesity, and spondylosis (neck arthritis). The MDS indicated R1 had received scheduled and as needed pain medication with an opioid pain medication having been administered, along with the use of diuretic, anti-anxiety, and anticoagulant (blood thinner) medications. R1's self-reported frequent pain impacted her sleep and limited her day to day activities, along with mild depression symptoms. In addition, R1 had bladder incontinence. On 4/21/21, at 11:05 a.m. R1's electronic medical record (EMR) was reviewed and identified the following comprehensive care plan problem categories: - Pressure ulcer, start date 11/2/20. - Activities, start date 1/19/21. - Nutritional status, start date 2/2/21. - Skin tear injury risk, reviewed/revised on 4/7/21. On 4/21/21, around 1:00 p.m. the ADON provided a paper copy of R1's comprehensive care plan which identified the following additional problem categories: - Pain, reviewed/revised on 4/21/21, at 11:50 a.m. - Adaptive Equipment, reviewed/revised on 4/21/21, at 12:03 p.m. - Hospice, reviewed/revised on 4/21/21, at 12:07 p.m. - Falls, reviewed/revised on 4/21/21, at 12:11 p.m. - Urinary incontinence, reviewed/revised 4/21/21, at 12:28 p.m.	2 555	monitored by the Director of Nursing and corrective actions will be taken if needed. This system will be in place on or before 05/21/2021. Susan Roberts, BSN, RN Director of Nursing will be responsible.	

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2 555	Continued From page 4 - ADL (activities of daily living) functional / rehabilitation potential for individual areas of transfers, toileting, personal hygiene, eating, dressing, bed mobility, bathing, reviewed/revised on 4/21/21, at 12:28 p.m. R1's medical record lacked a completed person centered comprehensive care plan to meet R1's preference and goals, which were measurable to address the resident's overall medical, physical, mental and psychosocial needs. R2's quarterly MDS, dated 1/28/21, identified R2 admitted to the facility on 8/27/20. Further, the MDS identified R2 had moderately impaired cognition, impaired hearing and vision, required extensive physical assist for ADL's, and was enrolled in hospice care. Diagnosis included dementia, anxiety, dysphagia, hemiplegia (left sided weakness) after a cerebrovascular accident (stoke), low back pain, and a wedge compression fracture to the lumbar (lower) vertebrae (spine). The MDS indicated R2 had received scheduled and as needed pain medication with an opioid pain medication having been administered, along with antidepressant medication. R1's self-reported occasional pain limited her day to day activities, along with mild depression symptoms. In addition, the MDS identified R2 had bowel and bladder incontinence, held food/food remnants in her mouth after meals, and utilized bed and chair alarms. On 4/21/21, at 11:31 a.m. R2's electronic medical record (EMR) was reviewed and identified the following comprehensive care plan problem categories: - Nutritional Status, reviewed/revised 10/29/20. - Pressure injury risk, reviewed/revised 11/12/20. - Hospice, reviewed/revised on 3/18/21.	2 555		

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2 555	Continued From page 5 - 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 individual areas of walking/wheeling, transfers, toileting, 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, 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 plan 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 resident 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 reviewed/revised date of 4/21/21, had been initially developed and placed in the EMR that	2 555		

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2 555	Continued From page 6	2 555		

day. The ADON acknowledged R1 and R2's incomplete comprehensive care plans should have been identified at a minimum during their first quarterly MDS assessment process after their initial admissions and explained "time constraints" related to job duties had been the main reason for the incomplete comprehensive care plans. She denied the facility had an auditing process in place to ensure comprehensive care plans were completed within required time frames.

When interviewed on 4/21/21, at 3:26 p.m. RN-B stated the RN Managers have three weeks to develop a resident's comprehensive care plan after their admission. She explained she would expect to see items on the care plan triggered from the admission MDS process or items such as resident impairments. Further, RN-B explained she would have expected to see a comprehensive care plan developed and revised as needed for residents admitted in August and October of 2020, especially since these residents should have had their care plans reviewed quarterly after their admissions. RN-B denied the facility had an auditing process in place to ensure comprehensive care plans were completed within required time frames.

A Mother of Mercy Care Planning policy, revised 11/2017, identified the facility would ensure a resident-centered plan of care was developed for each resident which included the resident's goals, preferences and strengths, assessed and expressed needs, which identified key networks and supports, planned interventions, and timeframe's related to treatment, wellness and recovery. The policy directed the RN Unit Manager completed a Plan of Care for each resident within 21 days of the admission date and

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	00634	A. BUILDING: _____ B. WING _____	C 04/22/2021

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

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2 555	Continued From page 7 they would ensure periodic review of the Plan of Care based on the Resident's individual needs when there were changes in goals, objectives, or interventions identified, when warranted by changes in the Resident's medical or behavioral health condition, and must be reviewed quarterly after the Resident's admission. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely development of resident comprehensive care plans within seven days after the completion of the comprehensive resident assessment. The facility should re-educate staff identified in the citation to policies and procedures, and audit all residents comprehensive care plans for completion compliance. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected	21980		4/26/21

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21980	Continued From page 8 maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	21980		

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21980	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of medication theft to the State Agency (SA) within 24 hours of the allegation for 1 of 1 residents (R1) reviewed for misappropriation of property. Findings include: R1's quarterly Minimum Data Set (MDS), dated 1/19/21, identified R1 had intact cognition and required limited to extensive physical assist with activities of daily living (ADLs). Diagnosis included congestive heart failure (CHF), morbid obesity, and spondylosis (neck arthritis). The MDS indicated R1 had received scheduled and as needed pain medication with an opioid pain medication having been administered. R1's self-reported frequent pain impacted her sleep and day to day activities. An initial report was submitted to the SA on 4/19/21, at 1:11 p.m. by the director of nursing (DON). The incident report identified an allegation of medication neglect in which R1 had an accurate reconciliation of her liquid Oxycodone (opioid pain medication) on 4/16/21 at 2:00 p.m.; however, on 4/17/21, at 6:00 a.m. the Oxycodone count was observed to be three milliliters (ml) "short." Further, the report identified R1 had received her Oxycodone doses and no injury to R1 had been noted. During interview on 4/21/21, at 12:38 p.m. registered nurse (RN)-A stated on 4/17/21, around 6:00 a.m. she and licensed practical nurse (LPN)-A approached the floor's medication cart to start the shift to shift controlled medication counting process, in which LPN-A removed R1's	21980	Tag: 1980 The error of not reporting has been corrected by the following: The Director of Nursing who submitted the report has reviewed the Department of Health protocols and reviewed the protocols with the Nurse Managers, who have access to report. In addition, the nurse who waited to report to anyone was instructed and reminded that she needed to report as soon as a discrepancy was found. The Director of Nursing will monitor that all protocols are followed in the future. This was corrected on 04/26/2021. Audits of complaints and alleged abuse will be conducted through June 15, 2021 for timeliness of reporting. Timely reporting will be reviewed at the next Quality Assurance meeting that is scheduled for June 15, 2021. Paul Gaebe, Administrator, will be responsible that the Director of Nursing ensures that the reporting is completed within 24 hours.	

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21980	Continued From page 10	21980		

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.

When interviewed on 4/21/21, at 2:11 p.m. the assistant director of nursing (ADON) stated she expected the nurses to contact the on-call nurse "right away" when a "considerable" medication discrepancy had been found. The ADON denied knowledge of a policy which provided information to staff on what was considered a reportable medication discrepancy amount and had been unable to define what a considerable medication discrepancy would consist of; however, she explained it would be "based on the nurses thinking at the time." The ADON verbalized she would have expected the on-call nurse to have been updated about the Oxycodone discrepancy the evening of 4/16/21 as allegations of medication theft required reporting to the SA within two hours of the allegation.

During interview on 4/21/21, at 3:26 p.m. unit manager (RN)-B stated if a liquid medication discrepancy were found of a "ml or more" it should be poured into a medication cup and measured with a syringe to ensure accuracy and

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potential need for further reconciliation. RN-B explained a two or three ml discrepancy would be "concerning" to her and would rise to the level of potentially needing to be reported to the SA "in less than 24 hours."

When interviewed via telephone on 4/21/21, at 5:56 p.m. nursing assistant (NA)-A stated on the evening of 4/16/21 she had overheard LPN-B tell LPN-A "the oxy was off by a bit" when she had walked by them as they stood at the medication cart.

During interview via telephone on 4/22/21, at 8:21 a.m. LPN-A stated she had visualized R1's liquid Oxycodone to be less than the narcotic book documented amount when she and LPN-B performed the 4/16/21's evening shift to shift controlled medication counting process. LPN-A stated LPN-B had explained the medication had been "off a couple of ml's" in which LPN-B indicated she had attempted to pour the medication back in the bottle after some had spilt in the plastic medication syringe holding sleeve; however LPN-B had been unable to "salvage any." LPN-A acknowledged the Oxycodone had been off approximately three ml's. LPN-A explained she had not followed up more on this with LPN-B and had not reported the discrepancy to any of the other nurses working that shift, the on-call nurse, or facility management. LPN-A confirmed the first time the discrepancy was reported to management had been on the morning of 4/17/21 when RN-A contacted the DON after that morning's shift to shift count. LPN-A acknowledged having been trained on abuse which included medication theft and explained abuse was to be reported within a minimum of two hours to her supervisor.

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21980	Continued From page 12 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 SA prior to 4/19/21. 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 misappropriation of resident property/financial exploitation included resident medications. The policy directed all suspected abuse, neglect, and/or maltreatment to be reported promptly in which an initial online report must be made immediately but no later than two hours to the SA whether the abuse and/or neglect was substantiated or not. Further, the policy directs staff, "When in doubt be sure to report," and that the administrator is to be notified immediately. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of drug diversion by nursing staff. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to	21980		

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21980	Continued From page 13 determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		