Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 15, 2022

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

RE: CCN: 245339
Cycle Start Date: November 2, 2022

Dear Administrator:

On December 13, 2022, the Minnesota Department(s) 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.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 15, 2022

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

Re: Reinspection Results
Event ID: Z4C112

Dear Administrator:

On December 13, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered
November 14, 2022

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

RE: CCN: 245339
Cycle Start Date: November 2, 2022

Dear Administrator:

On November 2, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 February 2, 2023 (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 May 2, 2023 (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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 11/02/2022

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 11/1/22, to 11/2/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H53395437C (MN87907) with a deficiency cited at F726. 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 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726		12/4/22

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

Electronically Signed | 11/23/2022

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

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F 726	Continued From page 1 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the assistant administrator (AA) was certified as a nursing assistant (NA) or had demonstrated competency prior to assisting residents with transfers and incontinence cares for 3 of 3 residents (R4, R5 and R6). In addition, the facility failed to ensure nursing staff received and demonstrated competency related to the use of mechanical lifts and other transfer aids for 5 of 5 NA's NA-A, NA-B, NA-C, NA-D and NA-E, and 1 of 1 trained medication aid (TMA)-A. This deficient practice had the potential to affect all 50 residents who resided in the facility who required the use or had the potential to require the use of a mechanical lifts, transfer aids or required assistance with personal cares. Findings include:	F 726	Facility: Mother of Mercy Nursing Home – Albany, MN Facility ID: 245339 Date of Survey: 11/1/2022 to 11/2/2022 Event: Z4C111 Identified Date of Completion: 12/4/2022 Tag Number/Description: F726 CFR(s): 483.35(a)(3)(4)(c) – Competent Nursing Staff, 2300 MN Rule 4658.0105 Competency Regulatory Requirements: 483.35 Nursing Services – The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or	

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F 726	Continued From page 2 R4 R4's quarterly Minimum Data Set (MDS) dated 10/9/22, identified R4 had diagnoses which included multiple myeloma of the lung (cancer), respiratory failure, diabetes, and anxiety. The MDS identified R4 had moderate cognitive impairment and was dependent on staff for transfers and required extensive assistance of two staff with activities of daily living (ADL's) of bed mobility, toileting, personal hygiene, and dressing. The MDS indicated R4 was incontinent of bowel. Review of R4's undated care plan, revealed R4 had a self-care deficit and required the use of a mechanical Hoyer lift (full body lift) with two staff for transfers. The care plan revealed R4 required assistance of two with toileting and required assistance with peri cares. R5 R5's quarterly MDS dated 10/3/22, identified R5 had diagnoses which included Alzheimer's disease, dementia, anxiety, and chronic obstructive pulmonary disease (COPD.) The MDS identified R5 had severe cognitive impairment, was totally dependent with ADLs of bed mobility, transfers, and toileting and required assistance of two staff. Review of R5's undated care plan, revealed R5 had a self-care deficit related to dementia and impaired cognition. The care plan indicated R5 required the assistance of two staff and a Hoyer lift for transfers.	F 726	maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with facility assessment requirement required at 483.70(e). • 483.35(a)(3) – The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. • 483.35(a)(4) – Providing care includes but is not limited to assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs. • 483.35(c) – Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan care. Description of how the requirements was not met: Based on the FORM CMS 2567 – The facility failed to ensure the assistant administrator was certified as a nursing assistant or had demonstrated competency prior to assisting residents with transfers. In addition, the facility failed to ensure nursing staff received and demonstrated competency related to the use of mechanical lifts and other transfer aids for nursing staff. This deficient	

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F 726	Continued From page 3 R6 R6's quarterly MDS dated 7/25/22, identified R6 had diagnoses which included dementia, post-traumatic stress disorder (PTSD), anxiety and diabetes. The MDS indicated R6 had severe cognitive impairment, was totally dependent with ADLs of bed mobility, transfers, and toileting and required assistance of two staff. Review of R6's undated care plan, revealed R6 had a self-care deficit related to dementia, PTSD and Bipolar disorder. The care plan identified R6 required the assistance of two staff and a Hoyer lift for transfers. Review of email chain correspondence dated 10/28/22, at 4:48 p.m. to 10/29/22, at 7:48 a.m. revealed the director of nursing (DON) sent out an email to the facility's registered nurses and director of staff development and administration. The email identified the DON had provided mechanical lift training to the assistant administrator (AA) and another staff member as of that day. The email revealed the AA was "very active on the floor with patient care." The email revealed the DON identified the goal was to complete competencies on all nursing staff as time allowed. During an interview on 11/1/22, at 11:20 a.m. NA-C indicated she had been working at the facility on 10/17/22, providing cares to residents who required assistance, when she was approached by the facility's AA who had offered to help her transfer residents, such as R4, with a mechanical lift. NA-C indicated she had asked AA if he was "okay" to assist with resident transfers and indicated AA had responded he could. NA-C	F 726	practice had the potential to affect all residents who resided in the facility who required the use of a mechanical lift, transfer aids or required assistance with personal cares. Plan of Correction Corrective Action for the affected resident(s): Licensed Nurses, trained medication aides, and nursing assistants were educated on the use of mechanical lifts and competency demonstration completed. Unlicensed personnel who provided direct patient resident care is no longer an employee at the facility. A facility wide communication was sent to all care center employees instructing them that unlicensed personnel are not able to assist with transferring or direct resident cares that require nursing competencies to be completed prior to cares being provided. The facility will take the following measures to ensure that the same practice will not recur: The facility policy for mechanical lifts was reviewed for accuracy by the Director of Nursing. Licensed Nurses, trained medication aides, and nursing assistants were educated on the use of mechanical lifts and competency demonstration completed. The unlicensed personnel who provided direct resident cares is no longer an	

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F 726	Continued From page 4 stated she had not been comfortable as she was unsure of his competency level and declined his assistance. NA-C indicated she had been working at the facility for several months and had not had any formal competency or skills training for use of the facility's mechanical lifts and transfer aids since she had been hired. During an interview on 11/1/22, at 1:33 p.m. registered nurse (RN)-B stated she had been made aware from several staff over the last few weeks AA had been assisting NAs with resident cares and transferring residents with mechanical lifts, which included R5. RN-B indicated she had been informed by the facility's leadership AA was able to answer call lights and assist residents with non-care needs, such as handing resident's items. RN-B stated she was not aware if the AA had any formal training in using the mechanical lifts previously. RN-B indicated she had significant concerns for resident safety and had been informed on 10/28/22, AA had received skills training of the use of mechanical lifts. RN-B stated she was not aware if AA had any prior training or certifications which allowed him to provide personal cares or assistance with transfers. RN-B indicated the facility has had several changes in leadership and management in the last years and felt staff training and competencies had not been offered or completed as needed. During an interview on 11/1/22, at 2:19 p.m. NA-B indicated she had been working at the facility for several years and could not recall the last time she had received any skills training or competency assessments with the use of mechanical lifts/transfer aids. NA-B stated AA had been assisting with answering call lights and with	F 726	employee at the facility. A facility wide communication was sent to all care center employees instructing them that unlicensed personnel are not able to assist with transferring or direct resident cares that require nursing competencies to be completed prior to cares being provided. The facility will identify other residents that have the potential to be affected in the same manner by: All residents who use the full mechanical lift, standing mechanical lift, and stand aid for transfers have the potential to be affected by the deficient practice. Facility monitoring of performance to ensure that solutions are maintained. The Director of Nursing or designee will conduct 5 audits per month of newly hired nursing assistants, trained medication aides, Licensed Practical Nurses, or Registered Nurses to ensure that the newly hired staff have completed the training on full mechanical lifts, standing mechanical lifts, and stand aids per the manufacturer’s competency checklist prior to providing cares and services to the residents. The Director of Nursing will present to the Quality Assurance Performance Improvement Committee the audit findings and the Quality Assurance Performance Improvement Committee will determine continuing periodic auditing.	

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F 726	Continued From page 5 transferring residents for the last few weeks off and on. NA-B indicated she was not aware if AA had any training to assist with transfers or resident cares, had questioned the AA and he had informed her he was able to as he was a paramedic. NA-B indicated she could not recall specific residents AA had assisted her with, though had no concerns. NA-B stated the facility has had several changes in leadership and management in the last years and felt staff training and competencies had not been offered or completed as needed. During an interview on 11/1/22, at 2:30 p.m. trained medication aid (TMA)-A indicated she had been working at the facility for several years and had not received any skills training or competency assessments for use of the mechanical lifts within the past few years. TMA-A indicated in the past, a few years ago, the facility would have annual skills training, where she was shown and had to return demonstrate the use of mechanical lifts, Hoyer (full body) sit to stand lift and transfer aid device. TMA-A indicated the facility has had several changes in leadership and management in the last years and felt staff training and competencies had not been offered or completed as needed. During an interview on 11/1/22, at 3:05 p.m. the facility administrator stated there had been a "blow up" at the facility when the AA had come to the facility over the weekend of 10/22/22, and 10/23/22, to answer call lights and assist with non-direct cares, when one of the nurses "got her panties in a bunch." The administrator indicated one of the nurses had informed him AA had assisted with resident transfers and personal cares. However, he indicated the AA had denied	F 726		

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F 726	Continued From page 6 assisting with any type of direct cares. The administrator stated he felt the AA had seen there were a few holes in the schedule over the weekend, and wanted to come and see if he could help answer call lights, opening/shutting blinds and passing meal trays. The administrator stated staff were expected to be trained on the use of mechanical lifts prior to use. He indicated the AA was a paramedic and he was not aware of any plans for AA to obtain his nurse aid certification. During an interview on 11/1/22, at 3:49 p.m. AA indicated he had been at the facility for a little over a month and had recently received training for using mechanical lifts to assist with resident transfers. AA stated he had been at the facility on 10/17/22, and had entered one of the nursing units to introduce himself to the staff, and assist with non-direct cares. AA indicated he answered a few call lights and had taken a lift into a resident's room. The AA stated he had been present in the room with a NA and a resident, though could not recall who the staff or resident were, and had stood to the side while the NA used a Hoyer lift (two-person full body lift) to transfer the unnamed resident. The AA stated he did not assist with the transfer in any way and had not touched the resident. The AA indicated he had come to the facility on Sunday, 10/23/22, for a few hours to introduce himself to staff and to assist with non-direct cares. AA stated he had not provided any cares or assisted any residents with transferring. The AA indicated he currently had his paramedics certification and had had his NA certification back in 2007, however confirmed he did not have a current certification to practice as a NA nor was he enrolled in a NA certification class to obtain certification. The AA stated he had never	F 726		

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F 726	Continued From page 7 practiced as a NA in the past. The AA indicated he had requested to be trained in the use of mechanical lift transfers and had received training on 10/28/22, by the DON. During an interview on 11/1/22, at 4:00 p.m. NA-A stated she had been working at the facility for several months and had come from another long-term care facility. NA-A indicated since her hire, she had not received any formal training to use the facility's mechanical lifts or had her competency evaluated. During an interview on 11/1/22, at 4:12 p.m. RN-A stated on 10/23/22, she was informed on that day and throughout the previous week, the facility AA had assisted NA's with resident transfers and incontinence cares, such as R4 and assisted transferring R5 and R6, both of which required the use of a Hoyer lift. RN-A indicated she had asked other staff and the DON if the AA had been trained or certified as a NA and had been able to assist with resident transfers and cares. RN-A indicated she had been told the AA would receive training on the use of mechanical lifts and was able to assist with non-direct cares. RN-A indicated on that day, she had texted AA and asked him to stop assisting with resident transfers as he was not currently certified as a NA or trained to transfer residents. Review of text message dated 10/23/22, revealed RN-A sent AA a text message which indicated she had heard he he had been assisting residents with transfers that day, requested him to stop transferring residents as he was not certified as a NA or trained on the use of lifts. The message thread revealed AA responded he was sorry and would update the DON.	F 726		

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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 726	Continued From page 8 During an interview on 11/2/22, at 10:02 a.m. NA-D indicated on 10/23/22, the AA had been on the first floor when R5's wife asked to lay him down. NA-D indicated she had placed R5's call light one, the AA responded and had offered to help her with transferring R5 as he required the use of a Hoyer lift and two staff. NA-D stated she had assumed the AA was a nurse as she had not met him prior to that time. NA-D indicated R5 was assisted to bed with the use of a Hoyer lift. NA-D indicated she had clipped the lift sling straps to the lift bar, ran the controls while the AA guided R5's body over the bed and into position while she lowered him to the bed. NA-D stated following R5's transfer into bed, the AA assisted to roll R5 to remove the lift sling and exited the room. NA-D indicated she worked for a pool agency and had been working at the facility since approximately January 2022. NA-D stated she had not received any type of training or competency assessment for the use of the facility's mechanical lifts. During an interview on 11/2/22, at 9:51 a.m. the facility's director of staff development indicated she had started at the facility approximately four months ago and had not started any education programs. She stated it appeared the facility used to provide skills training and competency assessments for NA and licensed nursing staff for a variety of areas, which included using a mechanical lift and transfer aids. The director indicated it appeared the facility had not provided skills training or competency assessments for nursing staff within the last couple of years. During a telephone interview on 11/2/22, at 11:31 a.m. NA-F indicated she had worked at the facility	F 726		

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F 726	Continued From page 9 for a couple of years and had received formal training on using mechanical lifts by the previous director of nursing and had not had any competency assessments since. NA-F indicated she had worked on 10/23/22, and had assisted R4 with cares during her shift. She stated she had been in with another resident when the AA approached her and notified her R4 had to use the bathroom. NA-F stated she had entered R4's room with AA and proceeded to assist R4 out of her recliner and into her bed with a Hoyer lift. NA-F stated AA assisted to guide R4 while she was in the sling over her bed and assisted to position her in bed. She indicated R4 had been incontinent of bowel and proceeded to assist R4 with incontinence cares while AA held R4 onto her side. NA-F stated she had assumed AA was an NA or had some type of training since he offered to help to her transfer and provide incontinence cares to R4. NA-F stated she had felt uncomfortable following R4's cares and contacted her charge nurse to ask if AA was allowed to assist with resident cares as it didn't "seem right to her." During an interview on 11/2/22, at 11:50 a.m. the DON indicated she was not aware AA had provided direct cares to residents during his time spent on the resident care units. The DON confirmed AA was not currently certified as a NA and was not scheduled for any NA training classes in the future. The DON confirmed AA had not been trained or had a competency assessed prior to 10/28/22, when he had requested to be trained in order to assist the nursing staff. The DON stated she had completed mechanical lift training with AA on 10/28/22. She indicated AA had previously had his NA certificate, though was not active since 2009. The DON confirmed the	F 726		

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F 726	Continued From page 10 facility had no processes in place to provide training on the use of mechanical lifts or to ensure staff were competent to use them prior to the survey. Personnel records were reviewed with the DON and the following was confirmed: -NA-A, was hired on 9/8/22, and had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts. -NA-E was hired on 8/25/22, and had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts. -NA-C was hired on 6/23/22, and had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts. -NA-D was a pool agency staff who started 1/10/22, had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts. -NA-B was hired on 8/9/18, and had received no training on the use of mechanical lifts or competency assessment of lift use since 2018. -TMA-A was hired on 5/6/02, and had received no training on the use of mechanical lifts or competency assessment of lift use since 2014. Review of a facility policy titled, Mechanical Lift - Full Mechanical Lift - Long Term Care revised 11/2021, identified it was the purpose of the policy to facilitate the safe transfer of a resident using the full mechanical lift, including but not limited to residents unable to bear weight during transfers, assisting resident who have fallen, and residents unable or unwilling to participate in transfers. The policy identified all personnel using a mechanical	F 726		

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F 726	Continued From page 11 lift to assist residents with transfers, will be educated on how to safely utilize the mechanical lifts and will complete competency checklist. The policy identified two trained personnel would assist with all transfers using the full mechanical lift. Review of a facility policy titled, Mechanical Lift - Standing Lift - Long Term Care revised 6/2021, identified it was the purpose of the policy to facilitate the safe transfer of a resident using the mechanical standing lift. The policy identified all personnel using a mechanical lift to assist residents with transfers, will be educated on how to safely utilize the mechanical lifts and will complete competency checklist. Review of a facility policy titled Nursing Department Staff Competency dated 4/27/18, identified it was the purpose of the policy to ensure all care providers were competent to perform responsibilities in their specific areas of clinical practice.	F 726		

Electronically delivered
November 14, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: Z4C111

Dear Administrator:

The above facility was surveyed on November 1, 2022 through November 2, 2022 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.

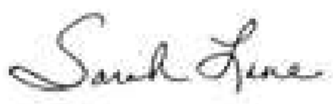
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,



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

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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 11/1/22, to 11/2/22, a complaint survey was conducted at your facility by surveyors 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 complaint was found to be SUBSTANTIATED: H53395437C (MN87907), with a licensing order issued at 0300. 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 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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the assistant administrator (AA) was certified as a nursing assistant (NA) or had demonstrated competency prior to assisting residents with transfers and incontinence cares for 3 of 3 residents (R4, R5 and R6). In addition, the facility failed to ensure nursing staff received and demonstrated competency related to the use of mechanical lifts and other transfer aids for 5 of 5 NA's NA-A, NA-B, NA-C, NA-D and NA-E, and 1 of 1 trained medication aid (TMA)-A. This deficient practice had the potential to affect all 50 residents who resided in the facility who required the use or had the potential to require the use of a mechanical lifts, transfer aids or required assistance with personal cares. Findings include: R4	2 300	Facility: Mother of Mercy Nursing Home – Albany, MN Facility ID: 245339 Date of Survey: 11/1/2022 to 11/2/2022 Event: Z4C111 Identified Date of Completion: 12/4/2022 Tag Number/Description: F726 CFR(s): 483.35(a)(3)(4)(c) – Competent Nursing Staff, 2300 MN Rule 4658.0105 Competency Regulatory Requirements: 483.35 Nursing Services – The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of	12/4/22

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2 300	Continued From page 3 R4's quarterly Minimum Data Set (MDS) dated 10/9/22, identified R4 had diagnoses which included multiple myeloma of the lung (cancer), respiratory failure, diabetes, and anxiety. The MDS identified R4 had moderate cognitive impairment and was dependent on staff for transfers and required extensive assistance of two staff with activities of daily living (ADL's) of bed mobility, toileting, personal hygiene, and dressing. The MDS indicated R4 was incontinent of bowel. Review of R4's undated care plan, revealed R4 had a self-care deficit and required the use of a mechanical Hoyer lift (full body lift) with two staff for transfers. The care plan revealed R4 required assistance of two with toileting and required assistance with peri cares. R5 R5's quarterly MDS dated 10/3/22, identified R5 had diagnoses which included Alzheimer's disease, dementia, anxiety, and chronic obstructive pulmonary disease (COPD.) The MDS identified R5 had severe cognitive impairment, was totally dependent with ADLs of bed mobility, transfers, and toileting and required assistance of two staff. Review of R5's undated care plan, revealed R5 had a self-care deficit related to dementia and impaired cognition. The care plan indicated R5 required the assistance of two staff and a Hoyer lift for transfers. R6 R6's quarterly MDS dated 7/25/22, identified R6	2 300	each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with facility assessment requirement required at 483.70(e). • 483.35(a)(3) – The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. • 483.35(a)(4) – Providing care includes but is not limited to assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs. • 483.35(c) – Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan care. Description of how the requirements was not met: Based on the FORM CMS 2567 – The facility failed to ensure the assistant administrator was certified as a nursing assistant or had demonstrated competency prior to assisting residents with transfers. In addition, the facility failed to ensure nursing staff received and demonstrated competency related to the use of mechanical lifts and other transfer aids for nursing staff. This deficient practice had the potential to affect all residents who resided in the facility who required the use of a mechanical lift,	

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2 300	Continued From page 4 had diagnoses which included dementia, post-traumatic stress disorder (PTSD), anxiety and diabetes. The MDS indicated R6 had severe cognitive impairment, was totally dependent with ADLs of bed mobility, transfers, and toileting and required assistance of two staff. Review of R6's undated care plan, revealed R6 had a self-care deficit related to dementia, PTSD and Bipolar disorder. The care plan identified R6 required the assistance of two staff and a Hoyer lift for transfers. Review of email chain correspondence dated 10/28/22, at 4:48 p.m. to 10/29/22, at 7:48 a.m. revealed the director of nursing (DON) sent out an email to the facility's registered nurses and director of staff development and administration. The email identified the DON had provided mechanical lift training to the assistant administrator (AA) and another staff member as of that day. The email revealed the AA was "very active on the floor with patient care." The email revealed the DON identified the goal was to complete competencies on all nursing staff as time allowed. During an interview on 11/1/22, at 11:20 a.m. NA-C indicated she had been working at the facility on 10/17/22, providing cares to residents who required assistance, when she was approached by the facility's AA who had offered to help her transfer residents, such as R4, with a mechanical lift. NA-C indicated she had asked AA if he was "okay" to assist with resident transfers and indicated AA had responded he could. NA-C stated she had not been comfortable as she was unsure of his competency level and declined his assistance. NA-C indicated she had been working at the facility for several months and had not had	2 300	transfer aids or required assistance with personal cares. Plan of Correction Corrective Action for the affected resident(s): Licensed Nurses, trained medication aides, and nursing assistants were educated on the use of mechanical lifts and competency demonstration completed. The facility will take the following measures to ensure that the same practice will not recur: The facility policy for mechanical lifts was reviewed for accuracy by the Director of Nursing. Licensed Nurses, trained medication aides, and nursing assistants were educated on the use of mechanical lifts and competency demonstration completed. The facility will identify other residents that have the potential to be affected in the same manner by: All residents who use the full mechanical lift, standing mechanical lift, and stand aid for transfers have the potential to be affected by the deficient practice. Facility monitoring of performance to ensure that solutions are maintained. The Director of Nursing or designee will conduct 5 audits per month of newly hired nursing assistants, trained medication aides, Licensed Practical Nurses, or	

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2 300	Continued From page 5 any formal competency or skills training for use of the facility's mechanical lifts and transfer aids since she had been hired. During an interview on 11/1/22, at 1:33 p.m. registered nurse (RN)-B stated she had been made aware from several staff over the last few weeks AA had been assisting NAs with resident cares and transferring residents with mechanical lifts, which included R5. RN-B indicated she had been informed by the facility's leadership AA was able to answer call lights and assist residents with non-care needs, such as handing resident's items. RN-B stated she was not aware if the AA had any formal training in using the mechanical lifts previously. RN-B indicated she had significant concerns for resident safety and had been informed on 10/28/22, AA had received skills training of the use of mechanical lifts. RN-B stated she was not aware if AA had any prior training or certifications which allowed him to provide personal cares or assistance with transfers. RN-B indicated the facility has had several changes in leadership and management in the last years and felt staff training and competencies had not been offered or completed as needed. During an interview on 11/1/22, at 2:19 p.m. NA-B indicated she had been working at the facility for several years and could not recall the last time she had received any skills training or competency assessments with the use of mechanical lifts/transfer aids. NA-B stated AA had been assisting with answering call lights and with transferring residents for the last few weeks off and on. NA-B indicated she was not aware if AA had any training to assist with transfers or resident cares, had questioned the AA and he had informed her he was able to as he was a	2 300	Registered Nurses to ensure that the newly hired staff have completed the training on full mechanical lifts, standing mechanical lifts, and stand aids per the manufacturer's competency checklist prior to providing cares and services to the residents. The Director of Nursing will present to the Quality Assurance Performance Improvement Committee the audit findings and the Quality Assurance Performance Improvement Committee will determine continuing periodic auditing.	

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2 300	Continued From page 6 paramedic. NA-B indicated she could not recall specific residents AA had assisted her with, though had no concerns. NA-B stated the facility has had several changes in leadership and management in the last years and felt staff training and competencies had not been offered or completed as needed. During an interview on 11/1/22, at 2:30 p.m. trained medication aid (TMA)-A indicated she had been working at the facility for several years and had not received any skills training or competency assessments for use of the mechanical lifts within the past few years. TMA-A indicated in the past, a few years ago, the facility would have annual skills training, where she was shown and had to return demonstrate the use of mechanical lifts, Hoyer (full body) sit to stand lift and transfer aid device. TMA-A indicated the facility has had several changes in leadership and management in the last years and felt staff training and competencies had not been offered or completed as needed. During an interview on 11/1/22, at 3:05 p.m. the facility administrator stated there had been a "blow up" at the facility when the AA had come to the facility over the weekend of 10/22/22, and 10/23/22, to answer call lights and assist with non-direct cares, when one of the nurses "got her panties in a bunch." The administrator indicated one of the nurses had informed him AA had assisted with resident transfers and personal cares. However, he indicated the AA had denied assisting with any type of direct cares. The administrator stated he felt the AA had seen there were a few holes in the schedule over the weekend, and wanted to come and see if he could help answer call lights, opening/shutting blinds and passing meal trays. The administrator	2 300		

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	00634	A. BUILDING: _____ B. WING _____	C 11/02/2022

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2 300	Continued From page 7 stated staff were expected to be trained on the use of mechanical lifts prior to use. He indicated the AA was a paramedic and he was not aware of any plans for AA to obtain his nurse aid certification. During an interview on 11/1/22, at 3:49 p.m. AA indicated he had been at the facility for a little over a month and had recently received training for using mechanical lifts to assist with resident transfers. AA stated he had been at the facility on 10/17/22, and had entered one of the nursing units to introduce himself to the staff, and assist with non-direct cares. AA indicated he answered a few call lights and had taken a lift into a resident's room. The AA stated he had been present in the room with a NA and a resident, though could not recall who the staff or resident were, and had stood to the side while the NA used a Hoyer lift (two-person full body lift) to transfer the unnamed resident. The AA stated he did not assist with the transfer in any way and had not touched the resident. The AA indicated he had come to the facility on Sunday, 10/23/22, for a few hours to introduce himself to staff and to assist with non-direct cares. AA stated he had not provided any cares or assisted any residents with transferring. The AA indicated he currently had his paramedics certification and had had his NA certification back in 2007, however confirmed he did not have a current certification to practice as a NA nor was he enrolled in a NA certification class to obtain certification. The AA stated he had never practiced as a NA in the past. The AA indicated he had requested to be trained in the use of mechanical lift transfers and had received training on 10/28/22, by the DON. During an interview on 11/1/22, at 4:00 p.m. NA-A stated she had been working at the facility for	2 300		

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2 300	Continued From page 8 several months and had come from another long-term care facility. NA-A indicated since her hire, she had not received any formal training to use the facility's mechanical lifts or had her competency evaluated. During an interview on 11/1/22, at 4:12 p.m. RN-A stated on 10/23/22, she was informed on that day and throughout the previous week, the facility AA had assisted NA's with resident transfers and incontinence cares, such as R4 and assisted transferring R5 and R6, both of which required the use of a Hoyer lift. RN-A indicated she had asked other staff and the DON if the AA had been trained or certified as a NA and had been able to assist with resident transfers and cares. RN-A indicated she had been told the AA would receive training on the use of mechanical lifts and was able to assist with non-direct cares. RN-A indicated on that day, she had texted AA and asked him to stop assisting with resident transfers as he was not currently certified as a NA or trained to transfer residents. Review of text message dated 10/23/22, revealed RN-A sent AA a text message which indicated she had heard he he had been assisting residents with transfers that day, requested him to stop transferring residents as he was not certified as a NA or trained on the use of lifts. The message thread revealed AA responded he was sorry and would update the DON. During an interview on 11/2/22, at 10:02 a.m. NA-D indicated on 10/23/22, the AA had been on the first floor when R5's wife asked to lay him down. NA-D indicated she had placed R5's call light one, the AA responded and had offered to help her with transferring R5 as he required the use of a Hoyer lift and two staff. NA-D stated she	2 300		

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2 300	Continued From page 9 had assumed the AA was a nurse as she had not met him prior to that time. NA-D indicated R5 was assisted to bed with the use of a Hoyer lift. NA-D indicated she had clipped the lift sling straps to the lift bar, ran the controls while the AA guided R5's body over the bed and into position while she lowered him to the bed. NA-D stated following R5's transfer into bed, the AA assisted to roll R5 to remove the lift sling and exited the room. NA-D indicated she worked for a pool agency and had been working at the facility since approximately January 2022. NA-D stated she had not received any type of training or competency assessment for the use of the facility's mechanical lifts. During an interview on 11/2/22, at 9:51 a.m. the facility's director of staff development indicated she had started at the facility approximately four months ago and had not started any education programs. She stated it appeared the facility used to provide skills training and competency assessments for NA and licensed nursing staff for a variety of areas, which included using a mechanical lift and transfer aids. The director indicated it appeared the facility had not provided skills training or competency assessments for nursing staff within the last couple of years. During a telephone interview on 11/2/22, at 11:31 a.m. NA-F indicated she had worked at the facility for a couple of years and had received formal training on using mechanical lifts by the previous director of nursing and had not had any competency assessments since. NA-F indicated she had worked on 10/23/22, and had assisted R4 with cares during her shift. She stated she had been in with another resident when the AA approached her and notified her R4 had to use the bathroom. NA-F stated she had entered R4's	2 300		

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2 300	Continued From page 10 room with AA and proceeded to assist R4 out of her recliner and into her bed with a Hoyer lift. NA-F stated AA assisted to guide R4 while she was in the sling over her bed and assisted to position her in bed. She indicated R4 had been incontinent of bowel and proceeded to assist R4 with incontinence cares while AA held R4 onto her side. NA-F stated she had assumed AA was an NA or had some type of training since he offered to help to her transfer and provide incontinence cares to R4. NA-F stated she had felt uncomfortable following R4's cares and contacted her charge nurse to ask if AA was allowed to assist with resident cares as it didn't "seem right to her." During an interview on 11/2/22, at 11:50 a.m. the DON indicated she was not aware AA had provided direct cares to residents during his time spent on the resident care units. The DON confirmed AA was not currently certified as a NA and was not scheduled for any NA training classes in the future. The DON confirmed AA had not been trained or had a competency assessed prior to 10/28/22, when he had requested to be trained in order to assist the nursing staff. The DON stated she had completed mechanical lift training with AA on 10/28/22. She indicated AA had previously had his NA certificate, though was not active since 2009. The DON confirmed the facility had no processes in place to provide training on the use of mechanical lifts or to ensure staff were competent to use them prior to the survey. Personnel records were reviewed with the DON and the following was confirmed: -NA-A, was hired on 9/8/22, and had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts.	2 300		

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2 300	Continued From page 11 -NA-E was hired on 8/25/22, and had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts. -NA-C was hired on 6/23/22, and had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts. -NA-D was a pool agency staff who started 1/10/22, had received no training on the use of mechanical lifts or competency assessment of lift use upon hire and prior to using the mechanical lifts. -NA-B was hired on 8/9/18, and had received no training on the use of mechanical lifts or competency assessment of lift use since 2018. -TMA-A was hired on 5/6/02, and had received no training on the use of mechanical lifts or competency assessment of lift use since 2014. Review of a facility policy titled, Mechanical Lift - Full Mechanical Lift - Long Term Care revised 11/2021, identified it was the purpose of the policy to facilitate the safe transfer of a resident using the full mechanical lift, including but not limited to residents unable to bear weight during transfers, assisting resident who have fallen, and residents unable or unwilling to participate in transfers. The policy identified all personnel using a mechanical lift to assist residents with transfers, will be educated on how to safely utilize the mechanical lifts and will complete competency checklist. The policy identified two trained personnel would assist with all transfers using the full mechanical lift. Review of a facility policy titled, Mechanical Lift - Standing Lift - Long Term Care revised 6/2021, identified it was the purpose of the policy to facilitate the safe transfer of a resident using the	2 300		

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2 300	Continued From page 12 mechanical standing lift. The policy identified all personnel using a mechanical lift to assist residents with transfers, will be educated on how to safely utilize the mechanical lifts and will complete competency checklist. Review of a facility policy titled Nursing Department Staff Competency dated 4/27/18, identified it was the purpose of the policy to ensure all care providers were competent to perform responsibilities in their specific areas of clinical practice. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to mechanical lift training and resident care plans and ensure plans are in place to assure staff are certified. DON or designee could provide training to the travel pool staff and with completing competency skills in these areas. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 300		