Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 6, 2024

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

RE: CCN: 245339
Cycle Start Date: July 19, 2024

Dear Administrator:

On August 27, 2024, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2024

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

Re: Reinspection Results
Event ID: UUV312

Dear Administrator:

On August 27, 2024, 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 July 19, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2024

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

RE: CCN: 245339
Cycle Start Date: July 19, 2024

Dear Administrator:

On July 19, 2024, 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:

Susie Haben, Rapid Response
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 October 19, 2024 (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 January 19, 2025 (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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
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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 07/19/2024

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 7/18/24 and 7/19/24, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53395820C (MN00104933), with deficiencies cited at F684 and F880. H53395840C (MN00104855), H53395820C (MN00104856), H53395821C (MN00104858), H53395822C (MN00104857), with a deficiency cited at F880. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		8/23/24

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

Electronically Signed | 08/09/2024

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 684	Continued From page 1 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure necessary care and services were provided to 1 of 1 resident (R1), whose severe environmental allergies were not adequately addressed to ensure she was comfortable and sufficiently protected from preventable allergy reactions. Additionally, when facility renovations were started, adequate barriers to prevent debris and chemical pollution from leaving the construction area were not maintained to protect R1. Findings include: During a facility tour on 7/18/24, at 9:39 a.m., the second-floor spa room had a sign on its closed door that indicated the room underwent a complete renovation which started on 7/8/24. The spa doorway was encased by a temporary non-zippered enclosed barrier made of plastic sheeting and wooden 2x4s. The barrier's entrance was a cut in the plastic that ran from the floor to about a foot from the ceiling and was unsecured to the floor, which caused a gap in the entrance. Observations were made through the plastic sheeting into the barrier; however, there was a fine film of white powdery substance on both the inside and outside of the plastic, along with the same powder on top of the fire extinguisher box to the left of the enclosure, when fingers were swiped across the surfaces outside of the barrier. The area was free of any strong odors; however, there was a faint smell of cut wood, directly in front of the enclosure opening. On 7/18/24, at 9:52 a.m., sounds heard from the	F 684	Plan of Correction for F684 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: • R1 monitored for signs and symptoms. • Care plan and Kardex updated to include sensitivity to perfumes, orders and allergens. • Signs and symptoms of allergic reaction added to the EMAR. • Sign on resident’s door indicating her sensitivity. • Sign when you enter the hallway R1 is on indicating that this is scent sensitive hallway. • R1 family does her laundry. • Oder free hand sanitizer offered to resident and staff. • Staff educated on residents’ sensitivity. 2. How other residents having the potential having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: • No residents have been identified to have been affected. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does	

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F 684	Continued From page 2 spa room were indicative of something being cut. On 7/18/24, at 10:38 a.m., the spa room was toured with the maintenance director (MD)-A. Two tile installers worked at installing tile. A commercial tile saw was present. The two air supply vents and two air return vents were all uncovered, and a box fan circulated air. Cut tile odors were smelt. R1's quarterly Minimum Data Set (MDS), dated 2/6/24, indicated R1 was cognitively intact. Her significant change MDS, dated 5/2/24, indicated R1 experienced shortness of breath (SOB) with exertion and was free of oxygen use. Diagnoses included chronic systolic congestive heart failure (CHF) and allergic rhinitis (an inflammation of the nasal membranes that is characterized by sneezing, nasal congestion, nasal itching, and rhinorrhea, in any combination). R1's electronic medical record (EMR) allergy listing identified R1 had 11 different drug allergies, and one environmental "Perfume" allergy. The EMR lacked evidence to identify the perfume allergy as identified upon admission documents, which was as a severe allergy with a designation of anaphylaxis for a reaction manifestation. R1's care plan, reviewed 7/18/24, identified the following: -A self-care deficit problem, revised 5/2/23, related to impaired mobility secondary to respiratory failure with hypoxia and left below the knee amputation (BKA). -An alteration in respiratory status, revised 4/19/23, related to diagnosis of Covid-19,	F 684	not recur: • Allergies will be identified on admission. Placed on resident dash board, care plan and EMAR. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. • The responsible party for this plan of correction will be the Executive Director/Administrator. The Director of Nursing. Including the Infection preventionist. • Social Services will meet with R1 weekly for 4 weeks to ensure deficient practice does not reoccur. Then monthly for 2 months or until R1 feels issue has been resolved whatever comes first. • The facility will review results of the audits and review with the QAPI committee.	

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F 684	Continued From page 3 respiratory failure with hypoxia, and CHF where R1 experienced SOB with exertion. 4/19/23 initiated interventions included oxygen (O2) as ordered, observe for respiratory signs/symptoms (s/s), labs as ordered, provide education as needed for appropriate breathing, relaxation techniques to help normalize breathing patters, and s/s of when to rest. The care plan lacked evidence of R1's perfume and medication allergies and any associated mitigating interventions, along with R1's preferences and her concerns with other odors and chemical uses for nursing and ancillary staff to follow. In addition, the care plan lacked s/s of respiratory and/or any additional medical impact(s) R1 experienced when she was exposed to allergens to assist staff in respiratory observations. R1's Electronic Medical Record (EMR) identified the following: -On 7/10/24 at 12:22 a.m., per a progress note, R1 requested a pain medication for right leg/foot pain and a headache. -On 7/10/24, a late entry at 12:00 p.m., per a progress note, the (previous) director of nursing (DON)-A (no longer employed with the facility) met with R1 and discussed R1's concerns related to possible allergic reactions to the air from construction. Her throat was scratchy, and she wanted an EpiPen readily available, in case she worsened. She denied anaphylaxis. Environmental precautions were discussed: she was offered a room change and an N95 mask, as well as standing order O2 initiation as needed (PRN) throughout the construction period. She	F 684		

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F 684	Continued From page 4 was pleased and declined a room change. Staff were advised to call emergency medical services (EMS) if symptoms progressed. -On 7/10/24, 1:33 p.m., per a progress note, R1 complained of allergy sensitivities due to construction smells. She was offered another room on a different floor; however, she declined and informed the nurse "it is in the ventilation system, it is just as bad on third floor." PRN Benadryl was provided and ineffective. An N95 was provided, along with O2 per her request for comfort. R2 requested an increase in the PRN Benadryl. Per the DON-A, if R1 requested, staff may call EMS for hospital transport. -On 7/10/24, per R1's order listing, O2 1-2 liters via nasal canula or 5-6 liters via mask was ordered. -On 7/10/24, per R1's order listing, Benadryl 50 mg twice a day (BID) PRN for nasal rhinitis and/or allergy was increased from 25 mg per R1's request due to "sensitivities with construction smells at facility." -On 7/10/24, at 4:54 p.m., per a progress note, the administrator, and the infection control preventionist (ICP) spoke with R1 to address her air quality concern. R1 wore an N95. R1 was informed the spa room demolition finished early morning on 7/9/24. R1 stated she still smelt the "fumes." She was offered to visualize the spa room and its "gutted" status. She was also offered a room change and declined as the fumes were in the vents. Staff interviewed after the visit with R1 declined they smelt any fumes/odors. -On 7/13/24, at 4:01 p.m., per a progress note,	F 684		

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F 684	Continued From page 5	F 684		

R1 complained of SOB, and she smelt a fragrance from the vents. O2 was applied, her door was opened, and a fan was utilized. These helped her.

- On 7/14/24, at 3:08 p.m., per a progress note, O2 was applied, R1 wore the N95, and the fans were on which provided R1 with relief.

- On 7/15/24, at 3:00 p.m., per a progress note, R1 requested a visit with social services. R1 ' could not take it any longer' and "[was] looking to move out." The note does not indicate her reasons. R1 was instructed to let social services know when she and her county worker found a location. She stated she could not live where there were communal areas due to her allergies.

- On 7/18/24, per R1's order listing, Benadryl 50 mg was increased to every six hours PRN from BID.

R1's Kardex (nursing assistant care plan), reviewed 7/18/24, identified R1's perfume allergy under an allergy heading; however, the Kardex lacked any additional information or risk mitigations related to this and/or her construction odor concerns.

During observation on 7/18/24, at 11:52 a.m., R1's door lacked signage to indicate any sort of allergy and/or any additional precautions to be aware of before one entered her room.

When interviewed on 7/18/24, at 11:52 a.m., R1 sat in her room with an N95 face mask on and was without supplemental O2. When the surveyor introduced herself, R1 exclaimed, "You are my last resort!" R1 identified a severe allergy to

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F 684	Continued From page 6 chemicals and provided a list of the top ones; however, she stated, "Anything made with chemicals, hand sanitizer is a deadly one for me." The list identified the following: shampoo, hair conditioner, styling products, laundry products, fabric softener/scent beads, perfumes, chloride, hand sanitizer, bleach, air freshener, alcohol, body wash and lotions. Due to this, she bought her own toilet paper and bathing products, family washed her laundry, and housekeeping cleaned her room with only water. She explained that she had dealt with these concerns for the past 30 years related to an in-home chemical spill accident that burnt her nose and throat. During the interview, R1 identified that a couple months ago a newer staff entered her room after they applied hand sanitizer. This started an increase in her allergy associated s/s. She had yet to completely recoup from that episode before her health again started to go backwards after there was an odor in the air the prior week on the second and third units that reminded her of "bug spray." This odor lasted all afternoon on 7/10/24 and some on 7/11/24. She thought this came from the vents. On 7/13/24 and 7/14/24, there was a completely different odor: a powdery fragrance. She pondered the 7/10/24 odor was from the wood utilized during the construction but did not know what other supplies were utilized by the workers. She stated she was not updated on the construction specifics or any associated risks to her health before it began, only that there would be construction and a new tub. R1 acknowledged she was offered a different room after her initial complaints on 7/10/24 but declined, as she felt the odors came from the vents, no matter where she went, she would smell them. Since the construction started, her speech was "choppy", and she required	F 684		

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F 684	Continued From page 7 supplemental O2 which she had not utilized since last summer. She attributed this to the construction odors, not the dust. Additionally, R1 stated, "I cannot continue to live like this." "I try to handle things myself but this last issue with my allergies, I just cannot take it anymore." She explained everyone knew, or should know, about her allergies, and other odor sensitivities. She was able to make her providers understand at times; however, "nothing work[ed] on the nurses." Facility management talked with her the previous week, after her complaints, and informed her there was nothing in the air or coming from the vents. As staff often told her they did not smell what she smelt, she felt staff did not believe her. R1 additionally vented her frustrations related to staff, especially management, who failed to take her seriously. She questioned, "Why would I ask for a mask and oxygen when I would not need it. I do not need their attention." She felt staff likely disbelieved how bad her allergies were, or they did not understand, or they did not care, adding "did not fit the norm" when it came to allergies. Immediately after R1's interview, a sign was observed on her closet door: located just inside her room door. The sign identified no chemicals, scents, and perfumes due to severe allergy. Surveyor had not noted this walking into the room, or while in the room for an extended period of time, only while exiting. On 7/18/24, at 12:38 p.m., a sign was observed on a unit restroom door, adjacent to R1's room, that identified "No Sprays, Scents, or Perfumes in this bathroom. This is a scent sensitive hallway." On 7/18/24, at 12:40 p.m., the spa door was wide open, and the room was free of construction	F 684		

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F 684	Continued From page 8 workers. A fan was positioned in the room and air was felt coming from the room. The plastic barrier sheeting doorway moved on its own. A fainter chemical/wet tile/grout like odor was smelt in the hallway. Shortly after, two construction workers entered the room and shut the door. When interviewed on 7/18/24, at 2:58 p.m., RN-A, who identified herself as the nurse manager, stated she was made aware of R1's construction concerns on 7/10/24; however, she did not get involved, nor performed any follow-up with R1, nor setup any respiratory monitoring for her. RN-A stated R1 was very sensitive to any smell(s): "hand sanitizer will set her off sometimes." At times, R1 overexaggerated and she felt R1 experienced more of a mental reaction versus a physical reaction to odors. RN-A explained R1's allergies and sensitivities were "just passed on from person to person" and if there were new staff, they went a little more in-depth with training related to things such as R1. In addition, staff obtained resident information via the care plan and the Kardex. RN-A reviewed R1's Kardex and care plan and acknowledged they lacked information related to R1's allergy concerns and risk mitigation. This information was expected to be there as it was very important information, even if some of R1's concerns were preferences and not true allergies. RN-A identified she would add this information to these items on 7/19/24. During an interview on 7/18/24, at 3:38 p.m. nursing assistant (NA)-A stated that on 7/8/24 R1 complained of a headache and queasy feeling related to odors within the facility. R1 was super sensitive to smells: just about to anything. She however was unaware of R1's hand sanitizer	F 684		

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F 684	Continued From page 9 sensitivity. She was expected to not wear fragrances, which she attempted to do. She identified the facility hired agency staff at times and explained information about residents was obtained from the Kardex, or care plan, and they were expected to review this information to ensure appropriate care. When interviewed on 7/18/24, at 3:45 p.m., NA-B stated R1 had allergies to fragrances and strong smells, especially hand sanitizer, and that R1 kicked staff out of her room if she smelt them in any way. On 7/8/24, R1 complained of chemical smells in the air. Since then, R1 reported someone told her there were chemicals in the vents. R1 currently utilized an N95 mask, kept her door open, windows open at times, and fans on to help mitigate odors being smelt. She identified R1 provided staff a list of specific information related to things that upset her allergies; however, it was some time since she saw that and could not remember specific details. NA-B felt this information was on R1's Kardex but was not 100 percent sure. She expected "any specific [resident] information to be on the Kardex for staff awareness. If not present, there was potential for R1's allergies to flareup, cause mental stress to R1, and/or cause R1 frustration and agitation. During an interview on 7/19/24, at 9:31 a.m., housekeeper (HSK)-A stated she entered R1's room to clean on 7/16/24 and R1 brought up perfume concerns. She reminded HSK-A to keep smells away from her. After she reiterated her knowledge of this to R1, R1 informed her someone that day entered her room with perfume on. HSK-A did not ask her for any additional details.	F 684		

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F 684	Continued From page 10 When interviewed on 7/19/24, at 10:35 a.m., the ICP stated she followed up with R1 on 7/10/24, 7/11/24, and 7/12/24 after R1 was observed with an N95. R1 was very sensitive to fragrances and smells and could not handle them, and thus staff were highly encouraged to not wear fragrances. She explained R1 reported potential anaphylaxis concerns related to this; however, RN-B was not aware of such a reaction since her admission. She identified, "a lot of staff education on wearing perfumes" was provided as "this [was] healthcare." If staff failed to follow risk mitigation for R1, risks to R1 would potentially be anxiety and panic. Staff needed to be proactive related to the potential anaphylaxis and resident safety was above everything else. Due to this, she expected this was on R1's care plan/Kardex to ensure all staff who worked with R1 were knowledgeable. If not there, she expected this to be immediately added. During an interview on 7/19/24, at 11:06 a.m., the interim director of nursing (DON) stated in situations such as R1's, she expected to see a notice on the resident's door and staff education. She also hoped this information was on the care plan for it to trigger the Kardex. However, she did not feel there were any real risks to R1 if this information was not on the care plan as there was a sign on her room door, and this "was enough," as staff saw this when they entered R1's room. The DON stated she was not overall familiar with the current spa construction and was unsure if there was any resident harm, or concerns, other than "one lady" who complained of odors and dust. She followed up with the statement, "Maybe mental harm, I do not know." When asked to clarify her statement, she identified R1 filed a police report; however, she was unsure as to	F 684		

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F 684	Continued From page 11 what the report stated. She was informed R1 called the police often and staff were not surprised when the police walked in. She denied she spoke with R1 after, or since, the police exited. On 7/19/24, at 11:21 a.m., an observation of R1's room door identified a lack of any precaution identification(s). During a follow-up interview with R1 on 7/19/24, at 11:22 a.m., R1 stated she experienced another episode when staff came into her room the prior evening. She did not initially react; however, right after the staff exited, she smelt an odor that caused her mouth to burn and needed the oxygen to clear her lungs. This delayed reaction occasionally occurred. R1 identified she often experienced a flight or fight response when she smelt odors that may cause breathing concerns because of how staff react to her and their unwillingness to protect her life. She does not feel safe here as there was nowhere for her to go to get away from the odors and she did not have enough strength to go outside when her symptoms occurred, and even if she did, she was required to pass by the essential oil staff. In addition, when she experienced increased breathing concerns, staff just told her to call 911. Overall, she expressed concerns if staff entered her room and had something on that triggered her anaphylaxis, she would die, as staff did not understand how significant her allergies to odors were. When interviewed on 7/19/24, at 11:49 a.m., for follow-up, RN-A stated, since 7/18/24, there were no conversations with other staff related to R1 and she had yet to update R1's care plan related	F 684		

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F 684	Continued From page 12 to allergies and preferences. When interviewed on 7/19/24, at 12:08 p.m., NA-C stated awareness of R1's allergies to perfumes and such. She identified that at one point in time the facility painted R1's unit and she moved to another. After R1 returned to her current unit, she stopped coming out of her room as she had previously. She felt R1 currently came out even less now compared to before the construction. R1's Kardex identified allergies; however, she was unaware of any details. Due to R1 allergies, she did not wear perfumes or other similar items at work. She identified, when she switched hair shampoo, R1 questioned her about it. Recently, R1 appeared more "sniffly," was more upset, had headaches, watery eyes, and stated she was itchy when she had reactions: "You can tell she is going through it." During a telephone interview on 7/19/24, at 1:44 p.m., R1's family member (FM)-A stated R1's concerns increased when "[management] stopped listening to [R1] in November ..." after there was a management change. She explained R1 felt her life was in danger as no one took R1's allergies seriously as they had prior to November. She explained R1's allergy history, history of medical neglect, and how she struggled with her many allergies and sensitivity fluctuations. She and R1 spoke daily. R1 updated her today of an incident that occurred later in the day prior (last evening). The encounter did not burn her mouth right away, but she was impacted shortly after. On 7/9/24, R1 contacted her and continued to call about every 10 minutes until she finally calmed down. She cried and was hysterical as she stated staff were going to kill her, nobody cared about the odors she smelt, and staff made her feel	F 684		

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F 684	Continued From page 13 stupid when they stated they smelt nothing and how they communicated with her at the time. FM-A thought R1's allergies and mitigations were on her care plan; however, had never fully verified this. She wanted this information added, "especially since they all know" about R1's condition. During a telephone interview on 7/22/24, at 9:48 a.m., the director of social services (DSS) stated R1 could not be around perfumes and currently pursued a different living situation in relation to her concerns. Staff attempted "very hard" to keep other staff out of R1's room who wore body sprays, but despite staff reminders, "that does not always connect with staff." She stated R1 now ate in her room as her throat closed-up when she went to the dining room. During recent conversations with R1, R1 was very fearful, she did not like the N95 but continued to wear it, and she did not trust anyone anymore. She was concerned none of her concerns were being addressed. Due to this, R1 called the ombudsman and the police. Her mood then was defensive and angry, but she calmed by the end of the conversation. DSS was unaware if R1's allergy concerns, and risk mitigation, were on the care plan; however, even if on the care plan, she felt nothing would change as staff failed to listen. During a telephone interview on 7/22/24, at 3:01 p.m., R1's medical provider (MD) identified R1's clinic record contained an extensive list of adverse reactions/allergies, which included a perfume allergy initially documented in 2012. He lacked remembrance of any recent conversations with R1, or staff, related to odors and reactions, nor any conversations about the construction and any potential impacts on R1, but recently she	F 684		

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F 684	Continued From page 14 requested Benadryl increases due to smells. With R1's provider visit on 7/18/24, R1 did not mention construction concerns and her respiratory exam was negative. MD explained, based on R1's perfume allergy, anyone who went into her room with perfume on was a concern due to her anaphylaxis risks. He expected staff with perfume to remain out of R1's room and commented the facility should be fragrance free. In addition, if he were in R1's shoes, and sincerely afraid of something happening when someone came into her room with perfume on, he would have a placard placed on her door to visible warn and/or remind others. Care plans were great, but realistically everyone who went into her room may not have access to her care plan. A Care Plans, Comprehensive Person-Centered policy, dated March 2022, identified a comprehensive, person-centered care plan, that included measurable, objectives and timetables, to meet the resident's physical, psychosocial and functional needs, was developed and implemented for each resident. The care plan was expected to be reviewed at routine intervals and when desired outcomes are not met and then revised as information about the resident and their condition(s) changed. An Abuse Prevention and Vulnerable Adult Procedure policy, dated 2/13/24, identified its purpose was to provide a safe living environment to all residents of the facility and indicated the following Mission Statement: "We are a community of concerned professionals working together to provide the best quality of life for those entrusted to us. We accomplish this Mission by maintaining a high standard of care for all, in a home-like atmosphere, which addresses	F 684		

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F 684	Continued From page 15 their physical, emotional, and spiritual needs."	F 684		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		8/23/24

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F 880	Continued From page 16 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control mitigation processes were timely and effectively implemented prior to, and during, facility demolition and renovations. In addition, the facility failed to hire a licensed, and certified contractor, to oversee the construction. This had the potential to impact all 51 residents within the	F 880	Plan of Correction for F880 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: • There is no evidence of any resident affected by deficient practice.	

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F 880	Continued From page 17 facility. Findings include: Between 7/12/24 and 7/15/24, five Common Entry Point (CEP) complaints were submitted to the State Agency (SA) from multiple residents. Concerns centered mainly around a construction project not being properly overseen by a licensed contractor and failure to adhere to Centers for Disease Control and Prevention (CDC) Long Term Care (LTC) construction guidelines for infection control (IC) and resident respiratory and safety protections. As a result, construction odors and dust traveled into resident areas and a potential black mold discovery was not properly remediated and removed. A CDC website, Part II. Recommendations for Environmental Infection Control in Health-Care Facilities, dated 1/11/24, identified the recommendations were part of the Guidelines for Environmental Infection Control in Health-Care Facilities (2003), which reflected a consensus of expert opinions and extensive consultation with agencies of the U.S. Department of Health and Human Services, and derived from empiric IC or engineering principles, theoretic rationale, scientific data, applicability, experience and/or evidence based practice. A section, C. II. Construction, Renovation, Remediation, Repair, and Demolition, identified the following recommendations: · It is strongly recommended, and/or required by state or federal regulation(s), the facility initially establishes a multidisciplinary team that includes IC staff to coordinate demolition and construction and to consider proactive preventive measures. · It is strongly recommended education be	F 880	2. How other residents having the potential having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: • No residents have been identified to have been affected. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: • Prior to “new” construction projects the facility will complete an ICAR assessment. Review ICAR assessment with safety committee which will include administrator, director of nursing, infection control nurse, nurse educator, maintenance and any other department pertinent to the safe completion of the project. • Executive director/Administrator will ensure that the contractors who are hired for the project are licensed contractors and follow CDC recommendations for renovations in a healthcare setting. • Signs will be posted for residents, visitors and staff notifying them of the construction projects and measures to minimized risk. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.	

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F 880	Continued From page 18 provided to the construction team and staff in immunocompromised resident areas regarding airborne infection risks associated with the project, fungal spores' dispersal during such activities, and methods to control it. · It is required by state or federal regulation(s) the facility incorporates mandatory adherence agreements for IC into construction contracts. · It is strongly recommended the facility establishes and maintains airborne environmental disease surveillance (e.g., fungus) as appropriate during project activities to ensure the health and safety of immunocompromised residents. · It is strongly recommended, and/or required by state or federal regulation(s), the facility implement IC measures relevant to the project. Before project implementation, perform an ICRA (Infection Control Risk Assessment) to define the scope of the project and the need for barrier measures. Determine if immunocompromised residents may be at risk of fungal spore exposure due to dust generation and develop an exposure contingency plan. For internal construction activities construct barrier(s) for resident area dust prevention which are impermeable to fungal spores and compliant with local fire codes. Block and seal off return air vents if rigid barriers are used for containment. Implement dust control measures on surfaces and divert pedestrian traffic away from work zones. Relocate residents who are adjacent to work zones, depending on immune status. · It is strongly recommended, and/or required by state or federal regulation(s) to perform engineering and work-site related IC measures as needed for internal projects. Ensure proper operation of air-handling system after erection of barriers and before the room or area is set to negative pressure. Create and maintain negative	F 880	• This project has been completed. • No Current projects. • All survey results will be reviewed with the QAPI committee.	

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F 880	Continued From page 19 air pressure in work zones adjacent to resident areas. Monitor negative air flow inside rigid barriers and to ensure barrier integrity; repair gaps or breaks in barrier joints. Wet-wiping tools and tool carts before their removal from the work zone. Placing mats with tacky surfaces inside the entrance; and covering debris and securing this covering before removing debris from the work zone. For ceiling tile removal, in resident care areas, use plastic sheets or prefabricated plastic units to contain dust; use negative pressure system within the enclosure to remove dust; and either pass air through an industrial grade, portable HEPA filter, or exhaust air directly to the outside. A facility provided list of immunocompromised residents, identified 41 residents were mildly to severely immunocompromised. A picture (screenshot) was anonymously provided. The picture was time stamped "Albany July 8 3:23 PM" and identified the spa room hallway. The picture lacked a barrier outside of the spa room door and the hallway floor showed a light dusting of a whiter colored substance. The substance was visualized about half-way down the hallway; however, was heavier by the spa area. Footprints were present throughout the substance. Facility provided email strings identified the following: -7/8/24, 12:12 p.m., the previous director of nursing (DON)-A (no longer employed at facility) updated the foundation director (FD) and the nurse manager (RN)-A with the CDC information website link to Part II. Recommendations for Environmental Infection Control in Health-Care	F 880		

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F 880	Continued From page 20 Facilities. This email asked if the contractors would ensure plastic barriers was put up to reduce dust to protect residents from dust and respiratory irritants. -7/8/24, at 4:06 p.m., the DON-A updated the maintenance director (MD)-A and the housekeeping supervisor (HS) with the CDC information website link and asked for assist to facilitate increased air exchange, increased air filter changes, and other environmental measures to prevent airborne fungal particles from affecting residents. DON-A provided email strings identified the following: -7/9/24, 8:54 a.m., the DON updated the administrator, the FD, and MD-A the contractor spoke to her that morning and "confirmed that there was quite a bit of exposed mold in that bathroom." She explained during construction projects, mold spores became airborne and thus they needed to protect their community from respiratory infections and any exacerbations of respiratory conditions. Given that risk, she again asked to purchase an approved air filtration system to clean mold spores from the air. She identified the construction workers wore N-95 masks during the renovation; however, she was concerned staff and residents were already affected and potentially needed additional assessments to recognize early signs of respiratory failure. "Today, the Construction team is building a barrier of wood and plastic to help contain the air to the workspace. As we noticed yesterday, the air travels throughout that wing of the facility." -7/9/24, at 9:04 a.m., the DON-A asked the Infection Control preventionist (ICP) to provide her with guidance on protections to be taken	F 880		

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F 880	Continued From page 21 during construction "given there is exposed mold." -7/9/24, at 7:33 p.m., the ICP responded and identified the DON-A could find this information in the policy book. If the DON-A was unable to locate, she would find it in the morning. The email identified no other information. A mold removal statement, dated 7/16/24, identified the maintenance director (MD)-A discovered "some mold" in the spa room, by the tub and shower, on 7/8/24. They cut out a section behind the tub about two-feet up and about four-feet wide, and two-feet all the way around the shower. The removed sheetrock was bagged up and brought to the dumpster. During a facility tour on 7/18/24, at 9:39 a.m., the second-floor spa room had a sign on its closed door that indicated the room underwent a complete renovation which started on 7/8/24, and thus was unavailable for use for three to four weeks. The following additional information was observed: -The spa doorway was encased by a temporary non-zippered barrier made of plastic sheeting and wooden 2x4s. The barrier's entrance was a cut in the plastic that ran from the floor to about a foot from the ceiling and was unsecured and opened approximately an inch. The edges of the barrier were attached to the hallway wall by green colored tape. The sides were secured to the ceiling and floor via wood boards. The entire front of the barrier was unsecured to the floor. The barrier failed to maintain a negative pressure status. -Visualization through the plastic sheeting was able to be conducted; however, there was a fine film of white powdery substance on both the	F 880		

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F 880	Continued From page 22 inside and outside of the plastic, along with the same powder on top of the fire extinguisher box to the left of the enclosure, when fingers were swiped across the surfaces outside of the barrier. -The area was free of any strong odors; however, there was a faint smell, possibly of cut wood, when directly in front of the enclosure opening. -The barrier lacked a sticky mat to collect dust/debris when exiting the spa/enclosure and the barrier lacked any sort of air-filtration system and/or process. -Inside the barrier were three five-gallon buckets. One, located just to the left of the spa door, up against the wall, contained an unknown murky liquid. Another bucket, closer to the unsecured barrier entrance, in front of the first bucket, contained an opened bag of powdered floor leveler. The third bucket, located just to the right of the spa door, contained unknown cloudy liquid. -A white piece of towel/blanket was haphazardly folded up and located between the barrier entrance and the spa door. -One resident room, who's door was wide open, was adjacent on the right side of the spa room and another resident room was across the hall from the adjacent room. On 7/18/24, at 9:52 a.m., sounds heard from the spa room were indicative of something being cut. On 7/18/24, at 10:34 a.m., a box fan circulated air from the direction of a centrally located unit nurse's station toward the unit that was adjacent to the spa housed unit. On 7/18/24, at 10:38 a.m., the spa room was toured with MA-D. Two tile installers worked at installing tile. A commercial tile saw was present. The two air supply vents and two air return vents	F 880		

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F 880	Continued From page 23 were all uncovered, and a box fan circulated air. The ceiling lacked tiles. An odor of cut tile was smelt. The room entryway lacked a sticky mat to collect dust/debris when exiting the room and the room lacked any sort of air-filtration system and/or process in addition to the air supply/return vents. The room was windowless. Upon exit of the spa room, MD-A confirmed one bucket contained floor leveler; however, was unsure about the contents of the other two buckets. During an interview on 7/18/24, at 10:44 a.m. MD-A stated the spa remodel project was planned by the administrator and the FD, and overseen by "volunteers," despite a previous lobby renovation project completed by hired contractors approximately a years ago. He was unaware of the volunteers (VOL)-A and VOL-B's qualifications, credentials, and/or licensure and he identified VOL-A oversaw the project. Prior to initiation, he knew the project was needed and when it started; however, he was not involved in any decision making, IC risk mitigation conversations, or in the volunteer recruitment process(es). He recommended, on multiple occasions, to hire a qualified contractor to ensure project steps were completed, and completed correctly, especially as there were risks volunteers were not knowledgeable and thus performed steps incorrectly. In addition, the volunteers may not know how to manage concerns that arose during the project. He participated in the initial demolition process but was unsure if there were any steps taken to identify possible mold, lead, and/or asbestos risks associated with the project. If found, a qualified company was required to assist with removal and remediation. On 7/8/24 during demolition, potential mold was discovered on an approximate	F 880		

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F 880	Continued From page 24 two foot by four-foot front section of sheetrock behind the free-standing tub. This section of sheetrock "looked wet;" however, he did not verify. There were non-odorous "black spots" that resembled "wet dust bunnies." Additional sheetrock was removed from behind the shower due to similar findings, but he did not visualize that area. After, the only actions taken were removal of the potential moldy sheetrock from these two areas, the sheetrock was placed in standard plastic bags, and the bags were transported through the facility to the dumpster. MD-A indicated VOL-A updated DON-A and the FD. The project was not stopped and there were no remediation's completed, despite thoughts they should have sprayed the room "to deter the spores from going all over." He was unaware of any facility construction related policies. Nor was he aware of requirements for IC risk mitigation, as the nurses and nurse managers were responsible for that. He identified the spa room vents were shut when they removed the blackened and wet sheetrock, and the workers wore N95 masks. A barrier was constructed after the demolition started which was free of any modifications. The barrier and/or the spa room lacked a negative pressure status and the HVAC system sucked up any air in the spa room and carried it outside. He denied the use of any additional air filtration processes. He last changed the air filters at the end of June and had not checked them since. He denied knowledge of any monitoring or surveillance to ensure air, odors, and/or particles remained in the spa room and did not migrate to resident areas. During a telephone interview on 7/18/24, at 1:52 p.m., the previous DON-A stated she initially was informed the construction would occur and its	F 880		

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F 880	Continued From page 25 timelines to assist with resident, family, and staff notifications, and to prepare for adjustment in bathing locations, along with staff were expected to help clean up and haul debris to the dumpster. No conversations occurred for assist with decision making and/or IC risk mitigation prior to construction. She was unfamiliar with VOL-A or VOL-B's names and/or their qualifications. On 7/8/24, the demolition process started around 9:00 a.m. Around noon, staff reported dust was everywhere. After, no construction workers were present in the spa room, and thus staff cleaned up the area. She updated FD and requested a barrier to protect everyone from the dust. On 7/9/24, in the morning, either VOL-A or VOL-B approached her to discuss her dust concerns. He identified there was a lot of mold and they needed help to clean it up. She explained to him there was a professional process required for mold remediation. He responded, 'We are a low budge project.' After she brought this to the attention of FD, MD-A, and the administrator, and provided them with information related to the above CDC guidelines and mold management, she was instructed to perform resident assessments but to leave the construction processes to the administrator, VOL-A, and VOL-B. She did not enter the spa room after she was updated on the mold. She instructed the workers to keep the door shut and reiterated the need for the barrier. She brought N95 masks to the unit and encouraged staff and residents to wear them, especially as no interventions for air purification were put into place. She emailed the IC preventionist (ICP) to inquire about construction policies as she was unable to find any. She denied resident respiratory monitoring/assessments were initiated.	F 880		

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F 880	Continued From page 26 When interviewed on 7/18/24, at 2:58 p.m., RN-A stated she was only updated about the spa renovation date and the need to adjust bath locations for the unit two residents for about three to four weeks. She was not involved in any renovation details or conversations related to IC risk mitigation. The demolition started the morning of 7/8/24, by non-professional volunteers, and continued through Tuesday. On 7/8/24, she brought dust concerns to the DON-A as there was dust being drug throughout the unit. No dust mitigation was done that day. After a morning meeting on 7/9/24, the DON-A brought up black mold concerns and a plastic barrier started to be erected around "midday." She heard only a little bit of mold was found and it was bagged as required; however, she did not witness any garbage bags hauled to the dumpster; only witnessed uncovered debris being hauled through the unit in wheelbarrows. Prior to the barrier completion, demolition again restarted, and was not completed until staff questioned them on its completion timeframe. The barrier remained unchanged since. No dust and/or odor mitigation was evident prior to the barrier's placement, and/or since. She visualized the spa room after demolition and observed all the sheetrock from about half the wall down was removed. She acknowledged immunocompromised residents on that unit; however, did not initiate any respiratory monitoring /assessments. Due to lack of respiratory monitoring, residents were susceptible to anaphylactic reasons, decreased respiratory status, and respiratory condition exacerbations, especially those already on oxygen. During an interview on 7/18/24, at 3:38 p.m., nursing assistant (NA)-A stated she was not involved in any resident discussions related to the	F 880		

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F 880	Continued From page 27 construction. She was just informed it would occur and when. She worked on 7/8/24, during the evening shift, and noted dust on the unit, especially by the spa room, as a "bunch of guys were going in and out" of the room. Due to the dust and the noise, staff attempted to keep resident doors shut as much as possible. NA-A was unsure when the barrier went up but indicated it was not installed on 7/8/24. She was unaware of any potential concerns discovered during demolition. When interviewed on 7/18/24, at 3:45 p.m. NA-B stated she worked the evening shift on 7/8/24 and visualized dust tracked "all down the unit." She assisted DON-A to mop up the dust. During an interview on 7/19/24, at 9:15 a.m., maintenance assistance (MA)-B stated he assisted the construction volunteers with demolition. He was unsure who the general contractor of the project was and/or the volunteers ' qualifications; however, VOL-B appeared to know what he was doing. During demolition "a little tiny bit of mold" was discovered by the shower and tub areas. This "little black area" was removed by VOL-A and VOL-B. He was unable to provide further details as "there were so many of us in there doing [demolition]," and mold "scared" him so he "did not dig into it." The black areas were just cut out and disposed of. MA-B explained there were initially no mitigation interventions put into place for dust and/or mold control, but after "a little bit" of dust escaped the room, in which footprints could be seen in the film on the floor, a barrier was placed. He was unsure if this occurred the first or second day of the demolition. He thought when he opened the spa door, air pushed into the room	F 880		

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F 880	Continued From page 28 and was sucked out of the vents. When interviewed on 7/19/24, at 9:31 a.m., the HS stated staff attempted their best to clean up after the dusty footprints which came from the spa room. This required mopping versus sweeping at least twice on 7/8/24. She denied involvement in conversations related to construction housekeeping processes. She just paid more attention to the details such as the extra dust. She stated MD-A updated her about the mold finding; however, no further conversations were had, and no precautions were taken for cleaning since. During an interview on 7/19/24, at 10:35 a.m., the ICP stated her role related to construction ensured residents and staffs' safety was monitored, they were not exposed to any contaminants, PPE (personal protective equipment) was available and utilized, and construction was performed in a safe manner. She denied the facility discussed IC risk mitigations, or performed an ICRA, prior to initiation. She was unaware of VOL-A or VOL-B's qualifications and/or IC knowledge. She was not within the facility when the demotion started but she discussed construction expectations in a morning standup which included PPE use and demolition safety such as no supplies or equipment in the hallways. She also updated staff there was a binder in her office related to construction policies and encouraged staff to contact her if concerns arose. She denied she setup resident respiratory/IC monitoring documentation; however, she spoke to DON-A and floor staff to remind them of the need for such monitoring. Initially the ICP denied there were concerns discovered during the demolition	F 880		

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F 880	Continued From page 29 process and identified "it was monitored very well." When she returned to work, she made sure nothing was missed. She stated maintenance monitored the air filters and they did not need to be switched out. When the ICP was questioned on potential mold during the demolition, she identified staff told her there was a dime/quarter size amount of a black colored mold found on the sheetrock on "Monday" (7/8/24). This was immediately removed, and the lower parts of the walls were also removed and inspected. There was no further mold found. She denied she spoke to VOL-A or VOL-B after she was updated on this. If mold was found, she expected this to be taken care of immediately; however, was not 100 percent sure of the process. Despite this, she stated the mold concern "was properly taken care of." She denied the spa room or barrier maintained a negative pressure; however, she deferred these types of questions to MD-A. She denied she set up resident respiratory monitoring despite an explanation that mold could potentially be "very harmful" to residents' respiratory systems, especially those already with respiratory concerns as this could cause a flare-up or respiratory illness. When interviewed on 7/19/24, at 11:06 a.m., the interim director of nursing (DON)-B stated most of the heavy spa construction was completed prior to her start date. She stated an overall lack of knowledge related to the construction but was updated there was a "small area" of mold which was safely removed. She denied involvement in any ongoing construction discussions to mitigate IC risk. During an interview on 7/19/24, at 12:42 p.m., the FD stated VOL-A and VOL-B were brought onto	F 880		

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F 880	Continued From page 30	F 880		

the project to "try to save as much money as possible," to be "frugal," and to get the project done as quick as possible for decreased disruptions. She was unsure how construction processes occurred without shutting the whole facility down. VOL-A was affiliated with the facility and VOL-B was recommended by VOL-A due to VOL-B's construction background. No contracts were signed with VOL-A or VOL-B. She was unaware of either VOL-A or VOL-B's qualifications and/or IC knowledge. Before demolition, the administrator reached out to Leading Age (long term care (LTC) member-led association) to inquire about construction requirements. The administrator was informed they did not need to worry about anything as they only replaced tile, flooring, and the tub; however, VOL-A and VOL-B were responsible to ensure construction requirements were completed. Despite this, neither provided any guidance other than the need to keep the spa door closed. FD explained she conversed with DON-A related to the construction and assumed she would have taken care of any IC risk mitigation. By the end of 7/8/24, the tiles were torn out and a "very concerning" "problem" was discovered. They "cleaned it up and put up a barrier." She explained a little bit of mold was found; however, no one knows if it was truly mold. She was told the insulation behind the tub was a darker discoloration. "They got it out within five minutes" and disposed of it. Once the DON-A was informed, she sent out emails that identified CDC guidelines as "you do not want it traveling through the air ..." But "it already did not seem like it was any different from the mold we would find in the kitchen sink if you pulled the sink out." VOL-B was not concerned about the mold as it was such a very little amount and thus neither was she. The

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F 880	Continued From page 31 mold was already removed before she was updated on its finding. The FD was unsure of the ICP role and/or actions related to the project and/or the mold but they took the input the DON-A provided to make sure there were no concerns after the mold was discovered. When interviewed via telephone on 7/19/24, at 1:53 p.m., VOL-A identified he knew construction based on his experience and building his own homes; however, he was not a licensed contractor. He assisted with the demolition and followed the directions of VOL-B, who was a licensed contractor. He reported he was unaware of LTC construction and/or IC regulations, or requirements for mold remediation and removal. VOL-A denied previous management of black mold but he "has seen lots of mold" which had always grown on things, was soft, and was furry-like. What he saw in the spa room was not "mold-like." It was darker in color "just black", but "not real dark," and nothing grew on it. It was noted on the back of the sheetrock, within the walls, when wet, soft, sheetrock was found by the tub and shower. These areas were removed, along with some additional areas where the sheetrock was also wet and darker in color. When this was discovered, they just removed it. He was unsure what was done for IC mitigation before, during, or after the mold was found, other than they wore N95 masks, kept the door closed, placed towels on the floor to decrease dust on their feet when they exited the spa room, and put up a barrier. In addition, he updated DON-A. When he updated her, he identified he "mentioned the word mold;" however, he "should not have used that word." During a telephone interview on 7/22/24, at 12:15	F 880		

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F 880	Continued From page 32 p.m. VOL-B stated he was only a volunteer in the project where he "just did the demo work and got it ready." He denied he was a licensed contractor; however, he owned a construction company which mainly did residential trimming and framing. He identified his knowledge for LTC/IC construction came from past employment and four pages of printed information that the FD provided to him. He read about a page and a half of this information but not all of it. He did not remember what the information he read pertained to other than keeping the dust and noise down. During demolition they plugged the vents with a bath towel to mitigate dust from escaping the spa room and put up a barrier outside the spa; however, no additional interventions were utilized to mitigate the spread of dust and/or odors. VOL-B denied any construction concerns. This interview was the first he heard of potential mold. He denied any conversations with DON-A during demolition and/or anyone else about mold. He stated the sheetrock by the shower and tub was "discolored a little bit," probably due to getting wet at one point and drying out. In addition, it was full of holes, thus the reason why it was cut out and replaced. When interviewed via telephone on 7/22/24, at 3:01 p.m., a medical provider (MD), who saw numerous facility residents, denied any IC risk mitigation discussions related to his patients prior to, or after the construction started. During an interview on 7/19/24, at 4:16 p.m., the administrator stated she contacted Leading Age and inquired into construction requirements. She was instructed, as they were not changing the footprint of the spa room, and just doing a face lift, they were not required to contact the State of	F 880		

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	245339	A. BUILDING _____ B. WING _____	C 07/19/2024

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F 880	Continued From page 33 MN or obtain any permits - just to make sure they installed slip resistant tiles, all the vents were closed, and a barrier was installed to prevent dust entering resident areas. In addition, she was informed they did not need specific, additional, air purification as they had a "fresh air exchange." She was unfamiliar with VOL-A and VOL-B and/or their qualifications. She thought VOL-A owned his own construction company, but she stated they probably should have checked into their credentials to ensure they were legitimate and that they were knowledgeable about construction and IC requirements. In addition, she lacked knowledge of LTC/IC construction requirements. She indicated the ICP did not provide any policies on construction IC. In addition, she was unaware of any overall facility construction policies. On 7/8/24, after the demolition started, the "construction workers" told her a small amount of black mold was found, which was something that "was common to see." They told her it was nothing to worry about and as they were construction workers, she did not question this. They cut it out, wrapped it up in plastic, and took it to the dumpster per compliance requirements. "It sounds as if they handled it perfectly." This was removed before she visualized it. DON-A sent out communications that identified requirements; however, she told the DON-A there was a fresh air exchange, the vents were tapped off, and there was no risk to anyone when they removed things. She indicated this was confirmed by "the construction workers." She explained the information provided by DON-A only applied to hospitals, and not them. A barrier went up on 7/8/24; however, this was after the demolition started. There was minimal dust in the hallways which only required a sweeping, and which did not even fill up a dustpan. She denied there were	F 880		

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F 880	Continued From page 34 meetings prior to the demolition to discuss IC risk mitigation or to perform any sort of risk assessments, or that she conducted, or instructed others to conduct, any construction risk audits. She was unfamiliar with ICRA. She denied the demolition was placed on hold after the finding of mold for remediation, as the amount found was so small. On 7/10/24, she and the ICP rounded in the facility to identify any concerns with residents and their respiratory statuses; however, there was no documentation of this. She identified, "We should have done better" with the construction process. A Construction and Renovation - Role of the Administrator or Designee(s) policy, dated 12/2006, the administrator or designee was to plan, implement, and supervise IC practices during construction, renovation, remediation, repair, and/or demolition of the facility in accordance with recommendations of the CDC, the Healthcare Infection Control Practices Advisory Committee (HICPAC), and state or local requirements to reduce resident and employee exposure of potentially infectious agents released into the environment due to such activities. The policy outlined the following administrative or designee responsibilities: review all plans prior to initiation and perform an ICRA for dust control and barrier measures, monitor such measures and other IC measures in accordance to recommendations, establish a multidisciplinary team that included IC staff and maintain a log of their activity, provide construction workers and staff educational information related to airborne infection risk to immunocompromised residents, dispersal of fungal spores and other dust-borne or airborne infection agents with methods to control such agents, review construction	F 880		

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F 880	Continued From page 35 contracts and incorporate mandatory adherence agreements for IC, establish and maintain surveillance for airborne and waterborne environmental disease to protect immunocompromised residents, and monitor projects until completion to ensure adherence to CDC/HICPAC guidelines and state or local requirements. A Construction & Renovation policy, dated 2023, identified the ICP, or designee, was to be involved in all aspects of construction or renovation to reduce potential infection or contamination risks and will perform a review and risk assessment to determine measures necessary for safety and to prevent the spread of infectious spores, bacteria, viruses, fungi, or contaminants. The ICP, administrator, maintenance, and the contractor(s) were to work together in all phases of demolition, construction, and renovation to achieve air contamination control during construction as this control was critical in all healthcare areas. The policy directed contractors were to limit the dissemination of airborne contaminants produced by construction-related activities using barriers, traffic control, ventilation, and timely removal of debris as dust in ceilings and construction debris contained fungal spores that could potentially cause infections in immunocompromised residents, visitors, and staff. In addition, the Construction and Renovation Guidelines and Checklist were to be provided to all contracts before construction initiation or renovation as part of the bid documents. Barriers were to be erected to contain dust/debris for dust-generating activities such as: demolition of walls, ceilings and ceiling tiles, wallboard, and ceramic tiles; sink and plumbing work that could result in	F 880		

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F 880	Continued From page 36 aerosolization of water in high-risk areas; exposure of ceiling spaces for demolition and for installation or rerouting of utility services; repairing of water damage. The policy additionally directed barrier types, housekeeping/environmental cleaning, construction traffic/transport in which debris was to be in covered carts, ventilation, water utility, construction site monitoring, and surveillance activities. The policy contained a link to CDC Guidelines for Environmental Infection Control in Health Care Facilities (2003).	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: UUV311

Dear Administrator:

The above facility was surveyed on July 18, 2024, through July 19, 2024, 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, Rapid Response
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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	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 7/18/24 and 7/19/24, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53395820C (MN00104933), H53395840C (MN00104855), H53395820C (MN00104856), H53395821C (MN00104858), H53395822C (MN00104857), with a licensing order issued at 1375. 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		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control mitigation processes were timely and effectively implemented prior to, and during, facility demolition and renovations. In addition, the facility failed to hire a licensed, and certified contractor, to oversee the construction. This had the potential to impact all 51 residents within the facility. Findings include: Between 7/12/24 and 7/15/24, five Common Entry Point (CEP) complaints were submitted to the State Agency (SA) from multiple residents. Concerns centered mainly around a construction project not being properly overseen by a licensed contractor and failure to adhere to Centers for	21375	Plan of Correction for F684 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: • R1 monitored for signs and symptoms. • Care plan and Kardex updated to include sensitivity to perfumes, orders and allergens. • Supplemental oxygen ordered for R1. However, R1 did not need or utilize. • Room change offered which R1 declined. 2. How other residents having the potential having the potential to be	8/9/24

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21375	Continued From page 3 Disease Control and Prevention (CDC) Long Term Care (LTC) construction guidelines for infection control (IC) and resident respiratory and safety protections. As a result, construction odors and dust traveled into resident areas and a potential black mold discovery was not properly remediated and removed. A CDC website, Part II. Recommendations for Environmental Infection Control in Health-Care Facilities, dated 1/11/24, identified the recommendations were part of the Guidelines for Environmental Infection Control in Health-Care Facilities (2003), which reflected a consensus of expert opinions and extensive consultation with agencies of the U.S. Department of Health and Human Services, and derived from empiric IC or engineering principles, theoretic rationale, scientific data, applicability, experience and/or evidence based practice. A section, C. II. Construction, Renovation, Remediation, Repair, and Demolition, identified the following recommendations: · It is strongly recommended, and/or required by state or federal regulation(s), the facility initially establishes a multidisciplinary team that includes IC staff to coordinate demolition and construction and to consider proactive preventive measures. · It is strongly recommended education be provided to the construction team and staff in immunocompromised resident areas regarding airborne infection risks associated with the project, fungal spores' dispersal during such activities, and methods to control it. · It is required by state or federal regulation(s) the facility incorporates mandatory adherence agreements for IC into construction contracts. · It is strongly recommended the facility establishes and maintains airborne environmental disease surveillance (e.g., fungus) as appropriate	21375	affected by the same deficient practice will be identified and what corrective action will be taken: • No residents have been identified to have been affected. Audit was conducted to identify residents who are immune compromised, have respiratory issues and allergies. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: • Residents will be identified upon admission with allergies. Care plans and Kardex will reflect allergies. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. • The responsible party for this plan of correction will be the Executive Director/Administrator. The Director of Nursing. Including the Infection preventionist. • The facility will review results of the audits and review with the QAPI committee.	

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21375	Continued From page 4 during project activities to ensure the health and safety of immunocompromised residents. · It is strongly recommended, and/or required by state or federal regulation(s), the facility implement IC measures relevant to the project. Before project implementation, perform an ICRA (Infection Control Risk Assessment) to define the scope of the project and the need for barrier measures. Determine if immunocompromised residents may be at risk of fungal spore exposure due to dust generation and develop an exposure contingency plan. For internal construction activities construct barrier(s) for resident area dust prevention which are impermeable to fungal spores and compliant with local fire codes. Block and seal off return air vents if rigid barriers are used for containment. Implement dust control measures on surfaces and divert pedestrian traffic away from work zones. Relocate residents who are adjacent to work zones, depending on immune status. · It is strongly recommended, and/or required by state or federal regulation(s) to perform engineering and work-site related IC measures as needed for internal projects. Ensure proper operation of air-handling system after erection of barriers and before the room or area is set to negative pressure. Create and maintain negative air pressure in work zones adjacent to resident areas. Monitor negative air flow inside rigid barriers and to ensure barrier integrity; repair gaps or breaks in barrier joints. Wet-wiping tools and tool carts before their removal from the work zone. Placing mats with tacky surfaces inside the entrance; and covering debris and securing this covering before removing debris from the work zone. For ceiling tile removal, in resident care areas, use plastic sheets or prefabricated plastic units to contain dust; use negative pressure system within the enclosure to remove dust; and	21375		

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21375	Continued From page 5 either pass air through an industrial grade, portable HEPA filter, or exhaust air directly to the outside. A facility provided list of immunocompromised residents, identified 41 residents were mildly to severely immunocompromised. A picture (screenshot) was anonymously provided. The picture was time stamped "Albany July 8 3:23 PM" and identified the spa room hallway. The picture lacked a barrier outside of the spa room door and the hallway floor showed a light dusting of a whiter colored substance. The substance was visualized about half-way down the hallway; however, was heavier by the spa area. Footprints were present throughout the substance. Facility provided email strings identified the following: -7/8/24, 12:12 p.m., the previous director of nursing (DON)-A (no longer employed at facility) updated the foundation director (FD) and the nurse manager (RN)-A with the CDC information website link to Part II. Recommendations for Environmental Infection Control in Health-Care Facilities. This email asked if the contractors would ensure plastic barriers was put up to reduce dust to protect residents from dust and respiratory irritants. -7/8/24, at 4:06 p.m., the DON-A updated the maintenance director (MD)-A and the housekeeping supervisor (HS) with the CDC information website link and asked for assist to facilitate increased air exchange, increased air filter changes, and other environmental measures to prevent airborne fungal particles from affecting residents.	21375		

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21375	Continued From page 6 DON-A provided email strings identified the following: -7/9/24, 8:54 a.m., the DON updated the administrator, the FD, and MD-A the contractor spoke to her that morning and "confirmed that there was quite a bit of exposed mold in that bathroom." She explained during construction projects, mold spores became airborne and thus they needed to protect their community from respiratory infections and any exacerbations of respiratory conditions. Given that risk, she again asked to purchase an approved air filtration system to clean mold spores from the air. She identified the construction workers wore N-95 masks during the renovation; however, she was concerned staff and residents were already affected and potentially needed additional assessments to recognize early signs of respiratory failure. "Today, the Construction team is building a barrier of wood and plastic to help contain the air to the workspace. As we noticed yesterday, the air travels throughout that wing of the facility." -7/9/24, at 9:04 a.m., the DON-A asked the Infection Control preventionist (ICP) to provide her with guidance on protections to be taken during construction "given there is exposed mold." -7/9/24, at 7:33 p.m., the ICP responded and identified the DON-A could find this information in the policy book. If the DON-A was unable to locate, she would find it in the morning. The email identified no other information. A mold removal statement, dated 7/16/24, identified the maintenance director (MD)-A discovered "some mold" in the spa room, by the tub and shower, on 7/8/24. They cut out a section behind the tub about two-feet up and about four-feet wide, and two-feet all the way around	21375		

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	00634	A. BUILDING: _____ B. WING _____	C 07/19/2024

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21375	Continued From page 7 the shower. The removed sheetrock was bagged up and brought to the dumpster. During a facility tour on 7/18/24, at 9:39 a.m., the second-floor spa room had a sign on its closed door that indicated the room underwent a complete renovation which started on 7/8/24, and thus was unavailable for use for three to four weeks. The following additional information was observed: -The spa doorway was encased by a temporary non-zippered barrier made of plastic sheeting and wooden 2x4s. The barrier's entrance was a cut in the plastic that ran from the floor to about a foot from the ceiling and was unsecured and opened approximately an inch. The edges of the barrier were attached to the hallway wall by green colored tape. The sides were secured to the ceiling and floor via wood boards. The entire front of the barrier was unsecured to the floor. The barrier failed to maintain a negative pressure status. -Visualization through the plastic sheeting was able to be conducted; however, there was a fine film of white powdery substance on both the inside and outside of the plastic, along with the same powder on top of the fire extinguisher box to the left of the enclosure, when fingers were swiped across the surfaces outside of the barrier. -The area was free of any strong odors; however, there was a faint smell, possibly of cut wood, when directly in front of the enclosure opening. -The barrier lacked a sticky mat to collect dust/debris when exiting the spa/enclosure and the barrier lacked any sort of air-filtration system and/or process. -Inside the barrier were three five-gallon buckets. One, located just to the left of the spa door, up against the wall, contained an unknown murky liquid. Another bucket, closer to the unsecured	21375		

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21375	Continued From page 8 barrier entrance, in front of the first bucket, contained an opened bag of powdered floor leveler. The third bucket, located just to the right of the spa door, contained unknown cloudy liquid. -A white piece of towel/blanket was haphazardly folded up and located between the barrier entrance and the spa door. -One resident room, who's door was wide open, was adjacent on the right side of the spa room and another resident room was across the hall from the adjacent room. On 7/18/24, at 9:52 a.m., sounds heard from the spa room were indicative of something being cut. On 7/18/24, at 10:34 a.m., a box fan circulated air from the direction of a centrally located unit nurse's station toward the unit that was adjacent to the spa housed unit. On 7/18/24, at 10:38 a.m., the spa room was toured with MA-D. Two tile installers worked at installing tile. A commercial tile saw was present. The two air supply vents and two air return vents were all uncovered, and a box fan circulated air. The ceiling lacked tiles. An odor of cut tile was smelt. The room entryway lacked a sticky mat to collect dust/debris when exiting the room and the room lacked any sort of air-filtration system and/or process in addition to the air supply/return vents. The room was windowless. Upon exit of the spa room, MD-A confirmed one bucket contained floor leveler; however, was unsure about the contents of the other two buckets. During an interview on 7/18/24, at 10:44 a.m. MD-A stated the spa remodel project was planned by the administrator and the FD, and overseen by "volunteers," despite a previous lobby renovation project completed by hired	21375		

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21375	Continued From page 9 contractors approximately a years ago. He was unaware of the volunteers (VOL)-A and VOL-B's qualifications, credentials, and/or licensure and he identified VOL-A oversaw the project. Prior to initiation, he knew the project was needed and when it started; however, he was not involved in any decision making, IC risk mitigation conversations, or in the volunteer recruitment process(es). He recommended, on multiple occasions, to hire a qualified contractor to ensure project steps were completed, and completed correctly, especially as there were risks volunteers were not knowledgeable and thus performed steps incorrectly. In addition, the volunteers may not know how to manage concerns that arose during the project. He participated in the initial demolition process but was unsure if there were any steps taken to identify possible mold, lead, and/or asbestos risks associated with the project. If found, a qualified company was required to assist with removal and remediation. On 7/8/24 during demolition, potential mold was discovered on an approximate two foot by four-foot front section of sheetrock behind the free-standing tub. This section of sheetrock "looked wet;" however, he did not verify. There were non-odorous "black spots" that resembled "wet dust bunnies." Additional sheetrock was removed from behind the shower due to similar findings, but he did not visualize that area. After, the only actions taken were removal of the potential moldy sheetrock from these two areas, the sheetrock was placed in standard plastic bags, and the bags were transported through the facility to the dumpster. MD-A indicated VOL-A updated DON-A and the FD. The project was not stopped and there were no remediation's completed, despite thoughts they should have sprayed the room "to deter the spores from going all over." He was unaware of	21375		

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21375	Continued From page 10 any facility construction related policies. Nor was he aware of requirements for IC risk mitigation, as the nurses and nurse managers were responsible for that. He identified the spa room vents were shut when they removed the blackened and wet sheetrock, and the workers wore N95 masks. A barrier was constructed after the demolition started which was free of any modifications. The barrier and/or the spa room lacked a negative pressure status and the HVAC system sucked up any air in the spa room and carried it outside. He denied the use of any additional air filtration processes. He last changed the air filters at the end of June and had not checked them since. He denied knowledge of any monitoring or surveillance to ensure air, odors, and/or particles remained in the spa room and did not migrate to resident areas. During a telephone interview on 7/18/24, at 1:52 p.m., the previous DON-A stated she initially was informed the construction would occur and its timelines to assist with resident, family, and staff notifications, and to prepare for adjustment in bathing locations, along with staff were expected to help clean up and haul debris to the dumpster. No conversations occurred for assist with decision making and/or IC risk mitigation prior to construction. She was unfamiliar with VOL-A or VOL-B's names and/or their qualifications. On 7/8/24, the demolition process started around 9:00 a.m. Around noon, staff reported dust was everywhere. After, no construction workers were present in the spa room, and thus staff cleaned up the area. She updated FD and requested a barrier to protect everyone from the dust. On 7/9/24, in the morning, either VOL-A or VOL-B approached her to discuss her dust concerns. He identified there was a lot of mold and they needed help to clean it up. She explained to him there	21375		

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21375	Continued From page 11 was a professional process required for mold remediation. He responded, 'We are a low budge project.' After she brought this to the attention of FD, MD-A, and the administrator, and provided them with information related to the above CDC guidelines and mold management, she was instructed to perform resident assessments but to leave the construction processes to the administrator, VOL-A, and VOL-B. She did not enter the spa room after she was updated on the mold. She instructed the workers to keep the door shut and reiterated the need for the barrier. She brought N95 masks to the unit and encouraged staff and residents to wear them, especially as no interventions for air purification were put into place. She emailed the IC preventionist (ICP) to inquire about construction policies as she was unable to find any. She denied resident respiratory monitoring/assessments were initiated. When interviewed on 7/18/24, at 2:58 p.m., RN-A stated she was only updated about the spa renovation date and the need to adjust bath locations for the unit two residents for about three to four weeks. She was not involved in any renovation details or conversations related to IC risk mitigation. The demolition started the morning of 7/8/24, by non-professional volunteers, and continued through Tuesday. On 7/8/24, she brought dust concerns to the DON-A as there was dust being drug throughout the unit. No dust mitigation was done that day. After a morning meeting on 7/9/24, the DON-A brought up black mold concerns and a plastic barrier started to be erected around "midday." She heard only a little bit of mold was found and it was bagged as required; however, she did not witness any garbage bags hauled to the dumpster; only witnessed uncovered debris being hauled through	21375		

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21375	Continued From page 12 the unit in wheelbarrows. Prior to the barrier completion, demolition again restarted, and was not completed until staff questioned them on its completion timeframe. The barrier remained unchanged since. No dust and/or odor mitigation was evident prior to the barrier's placement, and/or since. She visualized the spa room after demolition and observed all the sheetrock from about half the wall down was removed. She acknowledged immunocompromised residents on that unit; however, did not initiate any respiratory monitoring /assessments. Due to lack of respiratory monitoring, residents were susceptible to anaphylactic reasons, decreased respiratory status, and respiratory condition exacerbations, especially those already on oxygen. During an interview on 7/18/24, at 3:38 p.m., nursing assistant (NA)-A stated she was not involved in any resident discussions related to the construction. She was just informed it would occur and when. She worked on 7/8/24, during the evening shift, and noted dust on the unit, especially by the spa room, as a "bunch of guys were going in and out" of the room. Due to the dust and the noise, staff attempted to keep resident doors shut as much as possible. NA-A was unsure when the barrier went up but indicated it was not installed on 7/8/24. She was unaware of any potential concerns discovered during demolition. When interviewed on 7/18/24, at 3:45 p.m. NA-B stated she worked the evening shift on 7/8/24 and visualized dust tracked "all down the unit." She assisted DON-A to mop up the dust. During an interview on 7/19/24, at 9:15 a.m., maintenance assistance (MA)-B stated he assisted the construction volunteers with	21375		

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21375	Continued From page 13 demolition. He was unsure who the general contractor of the project was and/or the volunteers ' qualifications; however, VOL-B appeared to know what he was doing. During demolition "a little tiny bit of mold" was discovered by the shower and tub areas. This "little black area" was removed by VOL-A and VOL-B. He was unable to provide further details as "there were so many of us in there doing [demolition]," and mold "scared" him so he "did not dig into it." The black areas were just cut out and disposed of. MA-B explained there were initially no mitigation interventions put into place for dust and/or mold control, but after "a little bit" of dust escaped the room, in which footprints could be seen in the film on the floor, a barrier was placed. He was unsure if this occurred the first or second day of the demolition. He thought when he opened the spa door, air pushed into the room and was sucked out of the vents. When interviewed on 7/19/24, at 9:31 a.m., the HS stated staff attempted their best to clean up after the dusty footprints which came from the spa room. This required mopping versus sweeping at least twice on 7/8/24. She denied involvement in conversations related to construction housekeeping processes. She just paid more attention to the details such as the extra dust. She stated MD-A updated her about the mold finding; however, no further conversations were had, and no precautions were taken for cleaning since. During an interview on 7/19/24, at 10:35 a.m., the ICP stated her role related to construction ensured residents and staffs' safety was monitored, they were not exposed to any contaminants, PPE (personal protective equipment) was available and utilized, and	21375		

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21375	Continued From page 14 construction was performed in a safe manner. She denied the facility discussed IC risk mitigations, or performed an ICRA, prior to initiation. She was unaware of VOL-A or VOL-B's qualifications and/or IC knowledge. She was not within the facility when the demotion started but she discussed construction expectations in a morning standup which included PPE use and demolition safety such as no supplies or equipment in the hallways. She also updated staff there was a binder in her office related to construction policies and encouraged staff to contact her if concerns arose. She denied she setup resident respiratory/IC monitoring documentation; however, she spoke to DON-A and floor staff to remind them of the need for such monitoring. Initially the ICP denied there were concerns discovered during the demolition process and identified "it was monitored very well." When she returned to work, she made sure nothing was missed. She stated maintenance monitored the air filters and they did not need to be switched out. When the ICP was questioned on potential mold during the demolition, she identified staff told her there was a dime/quarter size amount of a black colored mold found on the sheetrock on "Monday" (7/8/24). This was immediately removed, and the lower parts of the walls were also removed and inspected. There was no further mold found. She denied she spoke to VOL-A or VOL-B after she was updated on this. If mold was found, she expected this to be taken care of immediately; however, was not 100 percent sure of the process. Despite this, she stated the mold concern "was properly taken care of." She denied the spa room or barrier maintained a negative pressure; however, she deferred these types of questions to MD-A. She denied she set up resident respiratory monitoring despite an explanation that mold could potentially	21375		

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21375	Continued From page 15 be "very harmful" to residents' respiratory systems, especially those already with respiratory concerns as this could cause a flare-up or respiratory illness. When interviewed on 7/19/24, at 11:06 a.m., the interim director of nursing (DON)-B stated most of the heavy spa construction was completed prior to her start date. She stated an overall lack of knowledge related to the construction but was updated there was a "small area" of mold which was safely removed. She denied involvement in any ongoing construction discussions to mitigate IC risk. During an interview on 7/19/24, at 12:42 p.m., the FD stated VOL-A and VOL-B were brought onto the project to "try to save as much money as possible," to be "frugal," and to get the project done as quick as possible for decreased disruptions. She was unsure how construction processes occurred without shutting the whole facility down. VOL-A was affiliated with the facility and VOL-B was recommended by VOL-A due to VOL-B's construction background. No contracts were signed with VOL-A or VOL-B. She was unaware of either VOL-A or VOL-B's qualifications and/or IC knowledge. Before demolition, the administrator reached out to Leading Age (long term care (LTC) member-led association) to inquire about construction requirements. The administrator was informed they did not need to worry about anything as they only replaced tile, flooring, and the tub; however, VOL-A and VOL-B were responsible to ensure construction requirements were completed. Despite this, neither provided any guidance other than the need to keep the spa door closed. FD explained she conversed with DON-A related to the construction and assumed she would have	21375		

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21375	Continued From page 16 taken care of any IC risk mitigation. By the end of 7/8/24, the tiles were torn out and a "very concerning" "problem" was discovered. They "cleaned it up and put up a barrier." She explained a little bit of mold was found; however, no one knows if it was truly mold. She was told the insulation behind the tub was a darker discoloration. "They got it out within five minutes" and disposed of it. Once the DON-A was informed, she sent out emails that identified CDC guidelines as "you do not want it traveling through the air ..." But "it already did not seem like it was any different from the mold we would find in the kitchen sink if you pulled the sink out." VOL-B was not concerned about the mold as it was such a very little amount and thus neither was she. The mold was already removed before she was updated on its finding. The FD was unsure of the ICP role and/or actions related to the project and/or the mold but they took the input the DON-A provided to make sure there were no concerns after the mold was discovered. When interviewed via telephone on 7/19/24, at 1:53 p.m., VOL-A identified he knew construction based on his experience and building his own homes; however, he was not a licensed contractor. He assisted with the demolition and followed the directions of VOL-B, who was a licensed contractor. He reported he was unaware of LTC construction and/or IC regulations, or requirements for mold remediation and removal. VOL-A denied previous management of black mold but he "has seen lots of mold" which had always grown on things, was soft, and was furry-like. What he saw in the spa room was not "mold-like." It was darker in color "just black", but "not real dark," and nothing grew on it. It was noted on the back of the sheetrock, within the walls, when wet, soft, sheetrock was found by the	21375		

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21375	Continued From page 17 tub and shower. These areas were removed, along with some additional areas where the sheetrock was also wet and darker in color. When this was discovered, they just removed it. He was unsure what was done for IC mitigation before, during, or after the mold was found, other than they wore N95 masks, kept the door closed, placed towels on the floor to decrease dust on their feet when they exited the spa room, and put up a barrier. In addition, he updated DON-A. When he updated her, he identified he "mentioned the word mold;" however, he "should not have used that word." During a telephone interview on 7/22/24, at 12:15 p.m. VOL-B stated he was only a volunteer in the project where he "just did the demo work and got it ready." He denied he was a licensed contractor; however, he owned a construction company which mainly did residential trimming and framing. He identified his knowledge for LTC/IC construction came from past employment and four pages of printed information that the FD provided to him. He read about a page and a half of this information but not all of it. He did not remember what the information he read pertained to other than keeping the dust and noise down. During demolition they plugged the vents with a bath towel to mitigate dust from escaping the spa room and put up a barrier outside the spa; however, no additional interventions were utilized to mitigate the spread of dust and/or odors. VOL-B denied any construction concerns. This interview was the first he heard of potential mold. He denied any conversations with DON-A during demolition and/or anyone else about mold. He stated the sheetrock by the shower and tub was "discolored a little bit," probably due to getting wet at one point and drying out. In addition, it was full of holes, thus the reason why it was cut out and	21375		

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21375	Continued From page 18 replaced. When interviewed via telephone on 7/22/24, at 3:01 p.m., a medical provider (MD), who saw numerous facility residents, denied any IC risk mitigation discussions related to his patients prior to, or after the construction started. During an interview on 7/19/24, at 4:16 p.m., the administrator stated she contacted Leading Age and inquired into construction requirements. She was instructed, as they were not changing the footprint of the spa room, and just doing a face lift, they were not required to contact the State of MN or obtain any permits - just to make sure they installed slip resistant tiles, all the vents were closed, and a barrier was installed to prevent dust entering resident areas. In addition, she was informed they did not need specific, additional, air purification as they had a "fresh air exchange." She was unfamiliar with VOL-A and VOL-B and/or their qualifications. She thought VOL-A owned his own construction company, but she stated they probably should have checked into their credentials to ensure they were legitimate and that they were knowledgeable about construction and IC requirements. In addition, she lacked knowledge of LTC/IC construction requirements. She indicated the ICP did not provide any policies on construction IC. In addition, she was unaware of any overall facility construction policies. On 7/8/24, after the demolition started, the "construction workers" told her a small amount of black mold was found, which was something that "was common to see." They told her it was nothing to worry about and as they were construction workers, she did not question this. They cut it out, wrapped it up in plastic, and took it to the dumpster per compliance requirements. "It sounds as if they handled it perfectly." This	21375		

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	00634	A. BUILDING: _____ B. WING _____	C 07/19/2024

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21375	Continued From page 19 was removed before she visualized it. DON-A sent out communications that identified requirements; however, she told the DON-A there was a fresh air exchange, the vents were tapped off, and there was no risk to anyone when they removed things. She indicated this was confirmed by "the construction workers." She explained the information provided by DON-A only applied to hospitals, and not them. A barrier went up on 7/8/24; however, this was after the demolition started. There was minimal dust in the hallways which only required a sweeping, and which did not even fill up a dustpan. She denied there were meetings prior to the demolition to discuss IC risk mitigation or to perform any sort of risk assessments, or that she conducted, or instructed others to conduct, any construction risk audits. She was unfamiliar with ICRA. She denied the demolition was placed on hold after the finding of mold for remediation, as the amount found was so small. On 7/10/24, she and the ICP rounded in the facility to identify any concerns with residents and their respiratory statuses; however, there was no documentation of this. She identified, "We should have done better" with the construction process. A Construction and Renovation - Role of the Administrator or Designee(s) policy, dated 12/2006, the administrator or designee was to plan, implement, and supervise IC practices during construction, renovation, remediation, repair, and/or demolition of the facility in accordance with recommendations of the CDC, the Healthcare Infection Control Practices Advisory Committee (HICPAC), and state or local requirements to reduce resident and employee exposure of potentially infectious agents released into the environment due to such activities. The policy outlined the following administrative or	21375		

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21375	Continued From page 20 designee responsibilities: review all plans prior to initiation and perform an ICRA for dust control and barrier measures, monitor such measures and other IC measures in accordance to recommendations, establish a multidisciplinary team that included IC staff and maintain a log of their activity, provide construction workers and staff educational information related to airborne infection risk to immunocompromised residents, dispersal of fungal spores and other dust-borne or airborne infection agents with methods to control such agents, review construction contracts and incorporate mandatory adherence agreements for IC, establish and maintain surveillance for airborne and waterborne environmental disease to protect immunocompromised residents, and monitor projects until completion to ensure adherence to CDC/HICPAC guidelines and state or local requirements. A Construction & Renovation policy, dated 2023, identified the ICP, or designee, was to be involved in all aspects of construction or renovation to reduce potential infection or contamination risks and will perform a review and risk assessment to determine measures necessary for safety and to prevent the spread of infectious spores, bacteria, viruses, fungi, or contaminants. The ICP, administrator, maintenance, and the contractor(s) were to work together in all phases of demolition, construction, and renovation to achieve air contamination control during construction as this control was critical in all healthcare areas. The policy directed contractors were to limit the dissemination of airborne contaminants produced by construction-related activities using barriers, traffic control, ventilation, and timely removal of debris as dust in ceilings and construction debris	21375		

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21375	Continued From page 21 contained fungal spores that could potentially cause infections in immunocompromised residents, visitors, and staff. In addition, the Construction and Renovation Guidelines and Checklist were to be provided to all contracts before construction initiation or renovation as part of the bid documents. Barriers were to be erected to contain dust/debris for dust-generating activities such as: demolition of walls, ceilings and ceiling tiles, wallboard, and ceramic tiles; sink and plumbing work that could result in aerosolization of water in high-risk areas; exposure of ceiling spaces for demolition and for installation or rerouting of utility services; repairing of water damage. The policy additionally directed barrier types, housekeeping/environmental cleaning, construction traffic/transport in which debris was to be in covered carts, ventilation, water utility, construction site monitoring, and surveillance activities. The policy contained a link to CDC Guidelines for Environmental Infection Control in Health Care Facilities (2003). Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including CDC, local and/or state, infection control recommendations during construction, remodeling, demolition, etc. Then the DON, or designee, could develop a checklist to utilize prior to, during, and after construction which incorporates all CDC, local, and/or state recommendations and/or requirements. After, the DON, or designee, could educate all staff in IC construction recommendations and facility expectations. Time Period for Correction: Twenty-one (21)	21375		

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21375	Continued From page 22 days.	21375		