Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2023

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

RE: CCN: 245339
Cycle Start Date: January 27, 2023

Dear Administrator:

On February 9, 2023, we notified you a remedy was imposed. On April 13, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 6, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 24, 2023 be discontinued as of April 6, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 9, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 24, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 3, 2023

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

Re: Reinspection Results
Event ID: MVY412

Dear Administrator:

On March 8, 2023 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 January 27, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2023

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

RE: CCN: 245339
Cycle Start Date: January 27, 2023

Dear Administrator:

On January 27, 2023, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 April 27, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 27, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

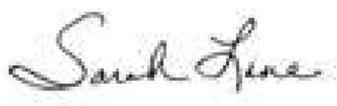
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



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

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 01/27/2023

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 1/25/23 - 1/27/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H53397643C (MN90349, MN90252), with a deficiency cited at F689. 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 689	Facility: Mother of Mercy Nursing Home –	3/1/23

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

Electronically Signed | 02/17/2023

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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	245339	A. BUILDING _____ B. WING _____	C 01/27/2023

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

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F 689	Continued From page 1 facility failed to develop interventions to reduce the risk for falls for 1 of 3 residents (R2) reviewed for accidents. Findings include: R2's quarterly Minimum Data Set dated 12/3/22, identified moderate cognitive impairment, indicated he required supervision for transfers, ambulation and toileting and was continent of bowel and bladder. R2's fall care plan dated 11/7/22, identified a risk for falls related to weakness, incontinence, impaired cognition and a history of falls. The care plan directed staff to encourage appropriate footwear, observe for adverse effects of medications and refer to therapy as indicated. The care plan was revised on 1/10/23, and indicated R2 required assist of one staff with wheel chair for locomotion. A facility incident report dated 12/17/22, at 1:33 p.m. indicated staff went to R2's room around 5:50 a.m. and saw him on the floor in front of the bathroom door. R2's wife stated he was checking on her and lost his balance. Investigation summary indicated R2 had a fall that was not suspicious in nature. R2 was impulsive and had poor safety awareness. After thorough review it was likely R2 was self transferring and fell. A facility incident report dated 12/18/22, at 10:55 a.m. indicated R2's wife utilized the call light and reported R2 had been sleeping in bed, rolled to the edge then slid onto the floor. An investigative summary indicated R2 fell out of bed. Fall not suspicious in nature. R2 was independent with transfers and bed mobility.	F 689	Albany, MN Facility ID: 245339 Date of Survey: 1/25/2022 to 1/27/2022 Identified Date of Completion: 3/1/2023 Tag Number/Description: F689 - D Regulatory Requirements: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Description of how the requirements was not met: The facility failed to develop interventions to reduce the risk for falls for 1 of 3 residents (R2) reviewed for accidents. FINDINGS: Fall 12/17, 12/18, 12/18, 12/21, 12/22, 12/26 lacked evidence of assessment of interventions, 1/7 post fall investigation was blank, 1/11. Medical record lacked evidence falls were assessed. Plan of Correction Corrective Action for the affected resident(s): R2 was no longer an active resident at the time of the survey, thus no corrective actions pertain specifically to R2. The facility will take the following measures to ensure that the same practice will not recur: Education has been initiated to provide nurses within the facility a review of the	

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F 689	Continued From page 2 A facility incident report dated 12/18/22, at 5:45 p.m. indicated staff found R2 on the floor after hearing him yell out. R2 was not wearing non-skid socks or shoes and was unable to give a description of what happened. A facility incident report dated 12/22/22, indicated R2 fell and landed on his left side. Fall was not suspicious in nature. R2 self-transferred and had poor safety awareness. Thorough review indicated R2 self transferred and fell. A Post-Fall Investigation dated 12/22/22, indicated on 12/21/22, at 10:30 p.m. R2 fell near his bed and was found seated on the floor between his bed and recliner. The report indicated R2 self-transferred and did not use his call light. Staff educate and monitor for safety every hour due to impulsive behavior and failure to utilize call light. The report indicated R2 displayed a drop in blood pressure upon standing which caused dizziness and unstable transfers. A physician visit note dated 12/22/22, indicated R2 was seen for increased weakness and falls and lift side rib pain. No physician recommendations were identified. A facility incident report dated 12/26/22, indicated R2 self transferred to the bathroom and was found on the floor in the bathroom. Investigation summary indicated R2 had a fall, not suspicious in nature. R2 was impulsive and displayed poor safety awareness. After thorough review, R2 was self-transferring and fell. A Post-Fall Investigation dated 12/26/22, indicated the fall was reviewed on 12/28/22, but lacked evidence of assessment of interventions.	F 689	facility's policy and procedure for Assessing Falls and Their Causes, Falls and Falls risk Managing, Fall Management, Fall Risk Management and the responsibility for thorough documentation of resident falls, contributing/root cause of the falls, as well as the implementation of fall interventions. All nurses and nursing leadership team members will have completion the education by 2/19/2023. The facility will identify other residents that have the potential to be affected in the same manner by: Nursing leadership will conduct an audit of the medical records of current residents who have experienced a fall within the last three months to assure that the fall was appropriately assessed for a root cause with an accompanying fall intervention established. Facility monitoring of performance to ensure that solutions are maintained. The Director of Nursing will complete a random audit of resident falls to assure the fall was appropriately documented and reviewed for a root cause with an accompanying fall intervention. The audit will be completed once a week for one month, then monthly until the next quarterly QA meeting where the results and response to the audits will be reviewed with members of the QA committee to determine the appropriateness/frequency of ongoing. Facility: Mother of Mercy Nursing Home Albany, MN	

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F 689	Continued From page 3 R2's Progress Note dated 12/28/22, indicated the physician directed staff to monitor R2's sleep habits and review in one week. The medical record lacked evidence of a review. A facility incident report dated 1/7/23, indicated R2 was found on the floor between beds, face down with his left arm under his body. He had some emesis present. R2 was sent to the hospital due to left side weakness and head injury resulting in a skin tear and hematoma formation. A Post-Fall Investigation dated 1/7/23, was blank. A facility incident report dated 1/11/23, indicated upon entering R2's room to check on him, he was seen sliding to the floor from his recliner. R2 was unable to describe what happened. Review of R2's medical record lacked evidence falls were assessed to determine a root cause and lacked evidence of interventions specific to R2's falls. During interview on 1/25/23, at 8:38 a.m. registered nurse (RN)-A stated R2 used to come out to the dining room for meals and was able to ambulate by himself using a cane. RN-A stated R2 spent most of the day sleeping and would take himself to the bathroom independently. RN-A stated R2 began having falls in the bathroom or in his room on the way to the bathroom. In regard to interventions, RN-A stated she would look on the care plan but did not know who developed the fall interventions. RN-A stated when a fall occurred the nurse on duty would document the details in an incident report. RN-A state she was not involved the review process.	F 689	Facility ID: 245339 Date of Survey: 1/25/2022 to 1/27/2022 Identified Date of Completion: 3/1/2023 Tag Number/Description: F689 - D Regulatory Requirements: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Description of how the requirements was not met: The facility failed to develop interventions to reduce the risk for falls for 1 of 3 residents (R2) reviewed for accidents. FINDINGS: Fall 12/17, 12/18, 12/18, 12/21, 12/22, 12/26 lacked evidence of assessment of interventions, 1/7 post fall investigation was blank, 1/11. Medical record lacked evidence falls were assessed. Plan of Correction Corrective Action for the affected resident(s): R2 was no longer an active resident at the time of the survey, thus no corrective actions pertain specifically to R2. The facility will take the following measures to ensure that the same practice will not recur: Education has been initiated to provide nurses within the facility a review of the facility's policy and procedure for	

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F 689	Continued From page 4 During interview on 1/26/23, at 6:51 a.m. RN-B stated R2 had been declining in his abilities the past few months and said the past month or so, assistance from staff was definitely needed. RN-B stated R2 had a bed alarm and stated he would forget he couldn't walk. RN-B stated staff checked on him often and tried to anticipate his needs. RN-B stated if she was present when a resident fell she completed the initial fall report and the unit manager and director of nursing (DON) completed the post fall report. During interview on 1/27/23, the DON stated falls were discussed in morning meetings to discuss each fall and allow the team to give input. The DON stated it "looked like" documentation was not being completed after the falls were reviewed. The DON said, "I think things were done but not documented. A facility policy Assessing Falls and Their Causes dated 07/2022, directed staff to complete and incident report no later than 24 hours after a fall and submit the form to the DON. The policy indicated after a fall occurred staff were to document details of the fall to include when the fall occurred and what the resident was trying to do at the time and begin to try to identify possible or likely causes of the incident. The policy directed staff to continue to collect and evaluate information until the cause of the fall was identified or it was determined the cause could not be found. The policy further directed staff to document appropriate interventions taken to prevent further falls.	F 689	Assessing Falls and Their Causes, Falls and Falls risk Managing, Fall Management, Fall Risk Management and the responsibility for thorough documentation of resident falls, contributing/root cause of the falls, as well as the implementation of fall interventions. All nurses and nursing leadership team members will have completion the education by 2/19/2023. The facility will identify other residents that have the potential to be affected in the same manner by: Nursing leadership will conduct an audit of the medical records of current residents who have experienced a fall within the last three months to assure that the fall was appropriately assessed for a root cause with an accompanying fall intervention established. Facility monitoring of performance to ensure that solutions are maintained. The Director of Nursing will complete a random audit of resident falls to assure the fall was appropriately documented and reviewed for a root cause with an accompanying fall intervention. The audit will be completed once a week for one month, then monthly until the next quarterly QA meeting where the results and response to the audits will be reviewed with members of the QA committee to determine the appropriateness/frequency of ongoing.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: MVY411

Dear Administrator:

The above facility was surveyed on January 25, 2023 through January 27, 2023 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.

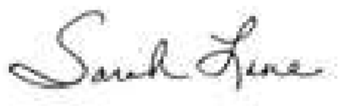
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00634	A. BUILDING: _____ B. WING _____	C 01/27/2023

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

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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 1/25/23 - 1/27/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00634	A. BUILDING: _____ B. WING _____	C 01/27/2023

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53397643C (MN90349, MN90252), with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop interventions to reduce the risk for falls for 1 of 3 residents (R2) reviewed for accidents. Findings include: R2's quarterly Minimum Data Set dated 12/3/22, identified moderate cognitive impairment, indicated he required supervision for transfers, ambulation and toileting and was continent of bowel and bladder.	2 830	Facility: Mother of Mercy Nursing Home – Albany, MN Facility ID: 245339 Date of Survey: 1/25/2022 to 1/27/2022 Identified Date of Completion: 3/1/2023 Tag Number/Description: F689 - D Regulatory Requirements: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and	3/1/23

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2 830	Continued From page 3 R2's fall care plan dated 11/7/22, identified a risk for falls related to weakness, incontinence, impaired cognition and a history of falls. The care plan directed staff to encourage appropriate footwear, observe for adverse effects of medications and refer to therapy as indicated. The care plan was revised on 1/10/23, and indicated R2 required assist of one staff with wheel chair for locomotion. A facility incident report dated 12/17/22, at 1:33 p.m. indicated staff went to R2's room around 5:50 a.m. and saw him on the floor in front of the bathroom door. R2's wife stated he was checking on her and lost his balance. Investigation summary indicated R2 had a fall that was not suspicious in nature. R2 was impulsive and had poor safety awareness. After thorough review it was likely R2 was self transferring and fell. A facility incident report dated 12/18/22, at 10:55 a.m. indicated R2's wife utilized the call light and reported R2 had been sleeping in bed, rolled to the edge then slid onto the floor. An investigative summary indicated R2 fell out of bed. Fall not suspicious in nature. R2 was independent with transfers and bed mobility. A facility incident report dated 12/18/22, at 5:45 p.m. indicated staff found R2 on the floor after hearing him yell out. R2 was not wearing non-skid socks or shoes and was unable to give a description of what happened. A facility incident report dated 12/22/22, indicated R2 fell and landed on his left side. Fall was not suspicious in nature. R2 self-transferred and had poor safety awareness. Thorough review indicated R2 self transferred and fell.	2 830	assistance devices to prevent accidents. Description of how the requirements was not met: The facility failed to develop interventions to reduce the risk for falls for 1 of 3 residents (R2) reviewed for accidents. FINDINGS: Fall 12/17, 12/18, 12/18, 12/21, 12/22, 12/26 lacked evidence of assessment of interventions, 1/7 post fall investigation was blank, 1/11. Medical record lacked evidence falls were assessed. Plan of Correction Corrective Action for the affected resident(s): R2 was no longer an active resident at the time of the survey, thus no corrective actions pertain specifically to R2. The facility will take the following measures to ensure that the same practice will not recur: Education has been initiated to provide nurses within the facility a review of the facility's policy and procedure for Assessing Falls and Their Causes, Falls and Falls risk Managing, Fall Management, Fall Risk Management and the responsibility for thorough documentation of resident falls, contributing/root cause of the falls, as well as the implementation of fall interventions. All nurses and nursing leadership team members will have completion the education by 2/19/2023. The facility will identify other residents that	

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2 830	Continued From page 4 A Post-Fall Investigation dated 12/22/22, indicated on 12/21/22, at 10:30 p.m. R2 fell near his bed and was found seated on the floor between his bed and recliner. The report indicated R2 self-transferred and did not use his call light. Staff educate and monitor for safety every hour due to impulsive behavior and failure to utilize call light. The report indicated R2 displayed a drop in blood pressure upon standing which caused dizziness and unstable transfers. A physician visit note dated 12/22/22, indicated R2 was seen for increased weakness and falls and lift side rib pain. No physician recommendations were identified. A facility incident report dated 12/26/22, indicated R2 self transferred to the bathroom and was found on the floor in the bathroom. Investigation summary indicated R2 had a fall, not suspicious in nature. R2 was impulsive and displayed poor safety awareness. After thorough review, R2 was self-transferring and fell. A Post-Fall Investigation dated 12/26/22, indicated the fall was reviewed on 12/28/22, but lacked evidence of assessment of interventions. R2's Progress Note dated 12/28/22, indicated the physician directed staff to monitor R2's sleep habits and review in one week. The medical record lacked evidence of a review. A facility incident report dated 1/7/23, indicated R2 was found on the floor between beds, face down with his left arm under his body. He had some emesis present. R2 was sent to the hospital due to left side weakness and head injury resulting in a skin tear and hematoma formation. A Post-Fall Investigation dated 1/7/23, was blank.	2 830	have the potential to be affected in the same manner by: Nursing leadership will conduct an audit of the medical records of current residents who have experienced a fall within the last three months to assure that the fall was appropriately assessed for a root cause with an accompanying fall intervention established. Facility monitoring of performance to ensure that solutions are maintained. The Director of Nursing will complete a random audit of resident falls to assure the fall was appropriately documented and reviewed for a root cause with an accompanying fall intervention. The audit will be completed once a week for one month, then monthly until the next quarterly QA meeting where the results and response to the audits will be reviewed with members of the QA committee to determine the appropriateness/frequency of ongoing. Facility: Mother of Mercy Nursing Home Albany, MN Facility ID: 245339 Date of Survey: 1/25/2022 to 1/27/2022 Identified Date of Completion: 3/1/2023 Tag Number/Description: F689 - D Regulatory Requirements: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Description of how the requirements was	

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2 830	Continued From page 5 A facility incident report dated 1/11/23, indicated upon entering R2's room to check on him, he was seen sliding to the floor from his recliner. R2 was unable to describe what happened. Review of R2's medical record lacked evidence falls were assessed to determine a root cause and lacked evidence of interventions specific to R2's falls. During interview on 1/25/23, at 8:38 a.m. registered nurse (RN)-A stated R2 used to come out to the dining room for meals and was able to ambulate by himself using a cane. RN-A stated R2 spent most of the day sleeping and would take himself to the bathroom independently. RN-A stated R2 began having falls in the bathroom or in his room on the way to the bathroom. In regard to interventions, RN-A stated she would look on the care plan but did not know who developed the fall interventions. RN-A stated when a fall occurred the nurse on duty would document the details in an incident report. RN-A state she was not involved the review process. During interview on 1/26/23, at 6:51 a.m. RN-B stated R2 had been declining in his abilities the past few months and said the past month or so, assistance from staff was definitely needed. RN-B stated R2 had a bed alarm and stated he would forget he couldn't walk. RN-B stated staff checked on him often and tried to anticipate his needs. RN-B stated if she was present when a resident fell she completed the initial fall report and the unit manager and director of nursing (DON) completed the post fall report. During interview on 1/27/23, the DON stated falls were discussed in morning meetings to discuss each fall and allow the team to give input. The	2 830	not met: The facility failed to develop interventions to reduce the risk for falls for 1 of 3 residents (R2) reviewed for accidents. FINDINGS: Fall 12/17, 12/18, 12/18, 12/21, 12/22, 12/26 lacked evidence of assessment of interventions, 1/7 post fall investigation was blank, 1/11. Medical record lacked evidence falls were assessed. Plan of Correction Corrective Action for the affected resident(s): R2 was no longer an active resident at the time of the survey, thus no corrective actions pertain specifically to R2. The facility will take the following measures to ensure that the same practice will not recur: Education has been initiated to provide nurses within the facility a review of the facility's policy and procedure for Assessing Falls and Their Causes, Falls and Falls risk Managing, Fall Management, Fall Risk Management and the responsibility for thorough documentation of resident falls, contributing/root cause of the falls, as well as the implementation of fall interventions. All nurses and nursing leadership team members will have completion the education by 2/19/2023. The facility will identify other residents that have the potential to be affected in the same manner by: Nursing leadership will conduct an audit of	

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2 830	Continued From page 6 DON stated it "looked like" documentation was not being completed after the falls were reviewed. The DON said, "I think things were done but not documented. A facility policy Assessing Falls and Their Causes dated 07/2022, directed staff to complete and incident report no later than 24 hours after a fall and submit the form to the DON. The policy indicated after a fall occurred staff were to document details of the fall to include when the fall occurred and what the resident was trying to do at the time and begin to try to identify possible or likely causes of the incident. The policy directed staff to continue to collect and evaluate information until the cause of the fall was identified or it was determined the cause could not be found. The policy further directed staff to document appropriate interventions taken to prevent further falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830	the medical records of current residents who have experienced a fall within the last three months to assure that the fall was appropriately assessed for a root cause with an accompanying fall intervention established. Facility monitoring of performance to ensure that solutions are maintained. The Director of Nursing will complete a random audit of resident falls to assure the fall was appropriately documented and reviewed for a root cause with an accompanying fall intervention. The audit will be completed once a week for one month, then monthly until the next quarterly QA meeting where the results and response to the audits will be reviewed with members of the QA committee to determine the appropriateness/frequency of ongoing.	