Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 4, 2024

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

RE: CCN: 245339
Cycle Start Date: October 10, 2024

Dear Administrator:

On November 25, 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

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December 4, 2024

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

Re: Reinspection Results
Event ID: 696512

Dear Administrator:

On November 25, 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 October 10, 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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Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2024

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

RE: CCN: 245339
Cycle Start Date: October 10, 2024

Dear Administrator:

On October 10, 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 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 January 10, 2025 (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 April 10, 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
625 Robert Street North
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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 10/10/2024

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 10/9/24 and 10/10/24, 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: H53399421C (MN00107231, MN00107098) H53399449C (MN00107305, MN00107311) with deficiencies cited at F755 and F580. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		11/21/24

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

Electronically Signed | 11/01/2024

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 580	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580		

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to contact the resident's physician of missed administration of medication for 1 of 1 resident (R2) reviewed for medication errors. The missed administration of medication resulted in a critical low potassium level of 2.4 mmol/L (millimoles per liter) (normal range 3.5 - 5.1 mmol/L). Findings include: R2's progress note dated 9/30/24 at 4:15 a.m. indicated on-call provider notified R2 had increased edema 3+ bilateral extremities (BLE) and increased pain. R2 had been admitted from hospital on 9/27/24 and discontinued diuretic Bumetanide (Bumex). Pain to BLE was 7/10 and edema 3+ from toes to knees. Ordered received administer Lasix (diuretic) 20 milligrams (mg) now and follow up with primary care provider (PCP) in morning. R2's progress note dated 10/1/24 at 1:14 p.m., seen by primary care provider (PCP) today on rounds. Add Bumex 2 milligrams (mg) daily for edema, weight daily for two week and check labs on Thursday, 10/3/24. R2's medication order start date 10/2/24 indicated Bumex oral tablet 2 mg by mouth one time a day related to edema. Order start date 10/2/24 and discontinued 10/8/24. R1's Electronic Medication Administration Record (EMAR) identified start date 10/2/24, and end date 10/8/24. Bumex oral tablet 2 mg, given by mouth one time a day related to edema was	F 580	Plan of correction for F580 Notify of changes 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: R1 has received her potassium per MD order on 10/8/2024. Potassium rechecked on 10/10/2024 potassium 3.2 returning to normal limits. Resident discharged to her home on 10/25/2024 in stable condition. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: Nurse managers will complete an audit of all residents Monday thru Friday with missed medication documented on MAR. Daily review in IDT stand up Monday thru Friday for follow up on the reason for missed medication and interventions. Nurse managers are reviewing progress notes to assure MD is notified with change of condition, missed or refused medication. 3. The measures the facility will take or systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not recur: All staff nurses have been in serviced on the facility s Notification of Resident Change in Condition policy and promptly	

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F 580	Continued From page 3 administered daily in morning on 10/2/24 through 10/8/24. R2's lab results dated 10/3/24 at 8:49 a.m. indicated potassium 2.8 mmol/L as low. The lab results were reviewed and acknowledged by physician assistant certified (PAC). R2's order dated 10/3/24 at 10:32 a.m., indicated start potassium 20 milliequivalents (mEq) twice daily, recheck basic metabolic panel (BMP) (measures calcium, carbon dioxide Chloride, Creatinine, glucose, potassium, sodium, blood urea nitrogen, to test body's kidney function) on Tuesday 10/8/24. Give 20 mEq by mouth two times a day related to hypokalemia. Order start date 10/3/24. Addressed on nursing home rounds. R2's progress note dated 10/3/24 at 8:28 p.m. indicated Orders-Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 (mEq) by mouth two times a day related to hypokalemia. Waiting on pharmacy. R1's Electronic Medication Administration Record (EMAR) identified start date 10/3/24, potassium chloride ER oral tablet 20 mEq by mouth two times a day related to hypokalemia. Potassium was signed off with a code #2 indicating not available from 10/3/24 at bedtime through 10/8/24 in the morning. R2 missed 10 doses. Potassium was signed off as given from 10/8/24, at bedtime through 10/10/24, in the morning. R2's admission Minimum Data Set (MDS) dated 10/4/2, identified R1 had intact cognition. R2's diagnoses included: cardiorespiratory conditions, pneumonia, and took a diuretic (removed fluid).	F 580	notifying a resident s representative of changes in condition and documenting the notification in the progress notes. All staff re-educated on policy of documentation of medication administration and medication administration. Guardian Pharmacy in serviced Nursing staff on “How to Prevent Medication Errors.” 4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent: 10/12/2024 daily monitoring Monday thru Friday for 4 weeks. Reviewing the EMAR for any missed medication, documentation and provider notification. Audits will be reviewed at monthly QAPI on November 21st to determine if additional auditing is necessary. The administer, director of nursing and designee will ensure compliance.	

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F 580	Continued From page 4 R2's progress note dated 10/4/24 at 9:33 a.m. Orders - Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. No supply. R2's progress note dated 10/4/24 at 4:41 p.m. Orders - Administration Note: Orders: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available R2's progress note dated 10/5/24 at 6:52 p.m., Orders - Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available - pharmacy faxed. R2's progress note dated 10/6/24 at 6:00 p.m. Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available. R2's potassium lab results 10/8/24 at 8:23 am., potassium 2.4 mmol/L low critical. R2's progress note dated 10/8/24 at 9:24 a.m. EMS called per provider's order due to low potassium level of 2.4 mmol/L. Currently waiting for arrival. R2's progress note dated 10/8/2024 at 3:30 p.m. Incident Note: Provider and son updated on missed medication administration of Potassium doses missed on 10/3/24, evening up to today 10/8/24.	F 580		

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F 580	Continued From page 5 During an interview on 10/10/24 at 9:10 a.m. licensed practical nurse (LPN)-A verified code number two entered in EMAR indicated medication was not available. LPN-A stated staff were expected to contact the provider after a medication error was made. During an interview on 10/10/24 at 12:30 p.m. R2's primary provider/medical doctor (MD)-A stated R2 was started on Bumex due to edema/swelling identified in lower extremities, and potassium level was to be rechecked on 10/3/24. MD-A stated R2's potassium level on 10/3/24 had dropped to 2.8 mmol/L and was started on potassium 20 mEq two times a day and recheck potassium level on Tuesday (five days later). MD-A stated he was informed on 10/8/24, R2 had not received the ordered potassium. MD-A stated would have expected staff to have contacted provider when it was discovered potassium had not been available. MD-A stated he was notified the potassium was not administered and first communication with him from staff was on 10/8/24. MD-A verified a low potassium would be concerning due the possibility of causing heart arrhythmia's (heart does not beat right, work correctly due to weak muscles and nerves caused by low potassium levels). During an interview on 10/10/24 at 1:30 p.m. floor manager/registered nurse (RN-B) stated when orders were received after rounds, they are entered into the system by medical record, then verified by the unit manager. RN-B stated R2's potassium was not received the evening on 10/3/24, and typically would wait until the next day and for what every reason it got missed. RN-B stated R2's potassium level was low at 2.4	F 580		

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F 580	Continued From page 6 mmol/L on 10/8/24, concerning, and should have been maintained within normal ranges to keep the body running. RN-B stated R2's trip to ER could have been prevented. RN-B stated she expected staff to have contacted the provider when a mediation error occurred and/or unable to administer the ordered mediation for further guidance/direction. During an interview on 10/10/24 at 3:34 p.m. LPN-B stated R2's potassium was low on 10/3/24 and ordered placed to start R2 on potassium. LPN-B stated R1 had not received the ordered potassium from 10/3/24, through 10/8/24, a.m. (10 doses) and was very concerning. LPN-B indicated when potassium levels were critical it would be a cardiac thing, heart does not work properly, could have resulted in a serious outcome, and provider should have been contacted regarding the medication error. During an interview on 10/10/24 at 4:15 p.m. LPN-C stated R2's potassium was not available to administer on two-day shifts (10/5/24 and 10/6/24) she had worked. LPN-C stated a fax was sent to pharmacy on 10/5/24, and they never responded. LPN-C stated the potassium was not at the facility the following day either was unaware the provider should have been contacted. LPN-C stated she had passed this information onto the oncoming shift. LPN-C stated R2's potassium level was low, and a provider should have been called for additional orders. Facility policy Adverse Consequences and Medication Errors dated 2001, identified the interdisciplinary team monitors medication usage in order to prevent and detect medication-related	F 580		

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F 580	Continued From page 7 problems such as adverse drug reactions and side effects. A medication error is defined as the preparation of drugs or biological which is not with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services. Example of a medication error: omission, a drug is ordered by not administered. A significant medication-related error was defined as hospitalization and required treatment with a prescription medication. In the event of a significant medication-related error or adverse consequence, take action as necessary, to protect the patient's safety and welfare. Provider should have been notified promptly of any significant error or adverse consequence. Communicate event to the oncoming shift as needed to alert staff for continued monitoring. Facility policy Change in Resident's Condition or Status dated 2021, identified a significant change in condition was a major decline or improvement in resident's status that without intervention by staff or implementing standard disease-related interventions (is not "self-limiting") and/or ultimately based on judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Except in medical emergencies, notifications will be made within twenty-four hours of a change in the resident's medical condition or status.	F 580		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed	F 755		11/21/24

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F 755	Continued From page 8 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potassium was available, administered timely and administered as prescribed by the physician for 1 of 1 resident (R2). R2 missed 10 doses of potassium resulting in a critical low potassium level of 2.4 mmol/L (millimoles per liter) (normal range 3.5 - 5.1 mmol/L) requiring IV potassium. R2 was asymptomatic and stable. Findings include:	F 755	Plan of correction for F755 Services/procedures/pharmacist/records 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: : R1 has received her potassium per MD order on 10/8/2024. Potassium rechecked on 10/10/2024 potassium 3.2 returning to normal limits. Resident discharged to her home on	

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F 755	Continued From page 9 R2's potassium lab results 9/27/24, potassium level 3.8 mmol/L. R2's progress note dated 9/30/24 at 4:15 a.m. indicated on-call provider notified R2 had increased edema 3+ bilateral extremities (BLE) and increased pain. R2 had been admitted from hospital on 9/27/24 and discontinued diuretic Bumetanide (Bumex). Pain to BLE was 7/10 and edema 3+ from toes to knees. Ordered received administer Lasix (diuretic) 20 milligrams (mg) now and follow up with primary care provider (PCP) in morning. R2's hospital follow-up visit dated 10/1/24, identified recently hospitalized for E. coli ((bacteria) pneumonia and septic shock that required an 11 day stay in the intensive care unit. R2 experienced pain due to fluid accumulation in legs, ankles, and believed addressing the fluid retention was necessary to alleviate her discomfort and retention of access fluid can be harmful. Due to R2's lower extremity edema most likely secondary to fluids received in hospital, she requested it be addressed. A lower dose of Bumex 2 milligrams (mg) was started and recheck kidney function on Thursday. R2's physical assessment showed lower bilateral (right /left) edema. Assessment/Plan follow-up based on lab work from Thursday as discussed. Discharge diagnosis: hypokalemia. R2's progress note dated 10/1/24 at 1:14 p.m., seen by primary care provider (PCP) today on rounds. Add Bumex 2 mg daily for edema, weight daily for two week and check labs on Thursday. R2's medication order start date 10/2/24 indicated	F 755	10/25/2024 in stable condition 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice. : Nurse managers will complete an audit of all residents Monday thru Friday with missed medication documented on MAR. Daily review in IDT stand up Monday thru Friday for follow up on the reason for missed medication and interventions. Nurse managers are reviewing progress notes to assure MD is notified with change of condition, missed or refused medication. 3. The measures the facility will take or systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not recur: All staff nurses have been in serviced on the facility s Notification of Resident Change in Condition policy and promptly notifying a resident s representative of changes in condition and documenting the notification in the progress notes. All staff re-educated on policy of documentation of medication administration and medication administration. Guardian Pharmacy in serviced Nursing staff on “How to Prevent Medication Errors.” Facility is meeting with pharmacy in November to improve communication. Implementation of texting GNote and Web Connect portal in process.	

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F 755	Continued From page 10 Bumex oral tablet 2 mg by mouth, one time a day related to edema. Order start date 10/2/24 and discontinue 10/8/24. R2's Electronic Medication Administration Record (EMAR) indicated start date 10/2/24, and end date 10/8/24. Bumex oral tablet 2 mg, give 2 mg by mouth one time a day related to edema was administered daily in morning on 10/2/24, through 10/8/24. R2's potassium lab results dated 10/3/24 at 8:49 a.m. identified potassium 2.8 mmol/L low critical were reviewed and acknowledged by PAC (physician assistant certified) (PAC). R2's order dated 10/3/24 at 10:32 a.m., indicated start potassium 20 mill equivalents twice daily, recheck BMP (basic metabolic panel) (measures calcium, carbon dioxide Chloride, Creatinine, glucose, potassium, sodium, blood urea nitrogen, to test body's kidney function) on Tuesday. Addressed on nursing home rounds. R2's medication order start date 10/3/24 indicated Potassium chloride extended release (ER) oral tablet 20 mEq. Give 20 mEq by mouth two times a day related to hypokalemia. Order start date 10/3/24. R2's progress note dated 10/3/24 at 8:28 p.m. indicated Orders-Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 milliequivalents (mEq) by mouth two times a day related to hypokalemia. Waiting on pharmacy. R2's medication order start date 10/3/24 indicated Potassium chloride extended release (ER) oral tablet 20 mEq. Give 20 mEq by mouth two times	F 755	4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent: 10/12/2024 daily monitoring Monday thru Friday for 4 weeks. Reviewing the EMAR for any missed medication, documentation and provider notification. Audits will be reviewed at monthly QAPI on November 21st to determine if additional auditing is necessary. The administer, director of nursing and designee will ensure compliance.	

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F 755	Continued From page 11 a day related to hypokalemia. Order start date 10/3/24. R2's Electronic Medication Administration Record (EMAR) indicated start date 10/3/24, potassium chloride ER oral tablet 20 mEq by mouth two times a day related to hypokalemia. Potassium was signed off with a code #2 (not available) on 10/3/24, HS (evening shift) through 10/8/24, a.m. (10 times). Potassium was signed off as given on 10/8/24, HS. through 10/10/24, a.m. R2's potassium lab results 10/3/24 at 8:49 a.m., potassium 2.8 mmol/L low critical. R2's admission Minimum Data Set (MDS) dated 10/4/2, identified R2 was admitted from the hospital on 9/27/24. R2's had intact cognition and no behaviors noted. R2's diagnoses included: cardiorespiratory conditions, pneumonia, and took a diuretic (removed fluid). R2's progress note dated 10/4/24 at 9:33 a.m. Orders - Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. No supply. R2's progress note dated 10/4/24 at 4:41 p.m. Orders - Administration Note: Orders: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available. R2's progress note dated 10/5/24 at 6:52 p.m., Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Med not available - pharmacy faxed.	F 755		

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F 755	Continued From page 12 Fax dated 10/5/24, sent from facility to pharmacy identified new order 10/3/24, R2 potassium chloride 20 mEq, need supply. Fax dated 10/5/24, sent from facility to pharmacy identified R2 potassium Chloride 20 mEq. R2's progress note dated 10/6/24 at 6:00 p.m. Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available. R2's potassium lab results 10/8/24 at 8:23 am., potassium 2.4 mmol/L low critical. R2's progress note dated 10/8/24 at 9:24 a.m. EMS called per provider's order due to low potassium level of 2.4 mmol/L. Currently waiting for arrival. R2's progress note dated 10/8/24 at 10:12 a.m. ER (emergency room) transfer note. Description of Change in Condition/Reason for Transfer: Low potassium level 2.4. Notified son and received verbal ok to send R2. Provider at facility gave order to transfer via ambulance to ER. R2's progress note dated 10/8/24 at 2:38 p.m. nurse's note: writer called the pharmacy to find out why R2 still had no potassium. Spoke with pharmacy staff and she stated she was unsure the reason why the order had not been filled. Pharmacy staff indicated would get medication sent out to facility today. Director of nursing (DON) updated. R2's Emergency Department (ED) visit dated	F 755		

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F 755	Continued From page 13 10/8/24 arrived at 10:39 a.m., identified 91-year-old woman sent in for treatment of hypokalemia, a critical lab value, potassium level of 2.4 mmol/L, after diuretics were started last week on a routine follow-up chemistry panel. R2 was recently hospitalized for sepsis (life threatening response to an infection) due to pneumonia and discharged from the hospital on 9/27/24. R2 was seen for hospital follow-up on 10/1/24 and started on Bumex. R2's labs were followed up on and the third her potassium was low at 2.8 mmol/L. R2 was started on oral potassium 20 mEq replacement twice daily. R2 was not entirely sure why she was brought by ambulance to the ED. R1's nursing home paperwork was reviewed, and the EMAR identified potassium was to be started on 10/3/24 and had not received a single dose because "medication was not available". R2 was asymptomatic (no symptoms), vitally stable able to take good oral intake. R2 was given intravenous (IV) potassium total of 20 mEq and oral replacement 40 mEq. Repeat potassium level was 2.9 mmol/L. R2 remained stable and asymptomatic during her stay. R2 had a prescription sent on October 3rd, 2024, to the pharmacy. The ED nursing staff called the nursing home and was informed they had been unable to get potassium from the pharmacy and/or any other pharmacy. R2's son was contacted, discussed this logistical problem, and was recommended until potassium can be obtained R2's Bumex be stopped that was used for chronic peripheral edema and not heart failure. R2's potassium prescription was sent to an alternative pharmacy and son agreed to pick up and bring to nursing home so that a supplied would be available. R2 was to have had a follow-up potassium level lab either Thursday or	F 755		

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F 755	Continued From page 14 Friday and message was sent to nursing home provider. Final impression: Hypokalemia. R2's progress note dated 10/9/24 at 12:00 a.m. Nurse's Note: [R2 returned from ER with Son at 6:00 p.m. New orders to stop Bumex, until potassium supplement can be obtained. Please allow family to bring in potassium tablets to use (if they can obtain from different pharmacy) . Son brought in Potassium 20 mEq tablets. Potassium administered at HS. R2's potassium lab results 10/10/24 at 8:32 a.m. potassium 3.2 mmol/L. Facility internal incident report, undated, identified potassium chloride ER (extended release) 20 mEq BID (two times a day) was ordered by provider on 10/3/24. First dose 10/3/24, evening shift. Potassium was not administered on 10/3/24, through 10/8/24, a.m. shift R2 sent to ED 10/8/24, for further evaluation. BMP (basic metabolic panel) identified potassium level 2.8 mmol/L. During an interview on 10/10/24 at 9:10 a.m. LPN-A verified code number two entered in EMAR indicated medication was not available. LPN-A stated staff should have contacted pharmacy by fax and if no response by telephone. LPN-A stated staff were expected to contact the provider after a medication error was made. During an interview on 10/10/24 at 12:00 p.m. pharmacy data entry staff (DE) verified received an e-script (electronic prescription) order for R2 on 10/3/24, potassium 20 mEq twice a day and sent to facility on 10/8/24. DE stated once the ordered was received by triage techs it was	F 755		

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F 755	Continued From page 15 moved to a week-to-week folder and should have been placed in the day-to-day folder. DE stated R2's potassium e-script identified up in left hand corner new RX which indicated either a new script or a refill which made the process more confusing, and triage missed that mark. DE verified the triage techs would be expected to have looked back into the R1's list of medications to have determined if it was new order or existing order. DE verified no additional faxes were received from the facility regarding R2's potassium once they received initial order on 10/3/24. During an interview on 10/10/24 at 12:30 p.m. R2's primary provider/medical doctor (MD)-A stated R2 was discharged from hospital on 9/27/24 and was not prescribed Bumex or potassium. MD-A indicated R2 had a follow-up hospital visit on 10/2/24, and edema/swelling was identified in her lower extremities bilaterally possible due to fluid buildup from intravenous fluids (IV). R2 was started on Bumex, and potassium level was to be rechecked on 10/3/24. MD-A stated R1's potassium level on 10/3/24 had dropped to 2.8 mmol/L and was started on potassium 20 mEq two times a day and recheck potassium level on Tuesday (five days later). MD-A stated he was informed on 10/8/24, R2 had not received the ordered potassium. MD-A indicated he gave order and facility sent R2 to ED and received potassium replacement. MD-A verified R2's Bumex was then held, had seen R2 this morning, and potassium level was up to 3.2 mmol/L. MD-A indicted R2's edema was most likely due to lymphedema (tissue swelling caused by accumulation of fluid) and heart function showed possible decreased function with a diastolic (lower heart chambers) cardiac problem	F 755		

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F 755	Continued From page 16 common for a 91 year old to have had some stiffness of the heart. MD-A stated would have expected staff to have contacted provider when it was discovered potassium had not been available. MD-A stated he was notified the potassium was not administered and first communication with him from staff was on 10/8/24. MD-A stated a potassium level of less than 3.0 mmol/L would draw out attention to address it in a stronger way and less than 2.5 mmol/L would be way too low and direct us to send to ED. MD-A verified a low potassium would be concerning due the possibility of causing heart arrhythmia's (heart does not beat right, work correctly due to weak muscles and nerves caused by low potassium levels). During an interview on 10/10/24 at 1:30 p.m. floor manager/registered nurse (RN-A) stated when orders were received after rounds, they are entered into the system by medical record, then verified by the unit manager. RN-A stated the provider sent the actual medication order to pharmacy through EPIC (electronic privacy information center) and unsure when that was done. RN-A stated would have expected to deliver on one of the two later runs (3 p.m. or between 9:00 p.m. - 10:00 p.m.). RN-A stated R2's potassium situation was a big Swiss cheese event because when stacked the holes were all in the same place and the process fell through the cracks. RN-A stated R2's potassium was not received the evening on 10/3/24, and typically would wait until the next day and for what every reason it got missed. RN-A stated facility staff sent a total of two faxes to pharmacy that requested the potassium to be sent over. The facility process has been revised our process and staff were expected to have picked up phone and	F 755		

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F 755	Continued From page 17 call pharmacy instead. RN-A indicted R2's diuretic/Bumex deplete potassium from her body and required replacement. RN-A stated R2's potassium level was low and concerning at 2.4 mmol/L and should have been maintained within normal ranges to keep the body running. RN-A stated yes harm had been done here, R2 did not have any ill effects from it but was facility responsibility to have had the potassium on hand and administer as ordered. RN-A stated R2's trip to ER could have been prevented and caused her undue anxiety. RN-A also stated along with EMS personal had informed R2's potassium level was extremely low and had to be sent to ER to get replacement for that. RN-B stated she expected staff to have contacted the provider when a mediation error occurred and/or unable to administer the ordered mediation for further guidance/direction. RN-A stated education/coaching forms were used to educated five out of the seven staff involved in lack of R1's administration of Potassium. RN-A stated the remaining two staff will be educated prior to the next start of their shift. RN-A indicated a mandatory nursing staff meeting will be held later this month to review this education and expectations for all nursing staff. During an interview on 10/10/24 at 3:34 p.m. LPN-B stated she had faxed pharmacy potassium was delivered per R2's order. LPN-B stated pharmacy had not replied, should have followed-up and called them. LPN-B stated could have possibly taken a potassium out of the emergency kit. LPN-B stated R2's potassium was low on 10/3/24, had not received 10 doses of potassium per order and was very concerning. LPN-B indicated when potassium levels are critical it would be a cardiac thing and heart does	F 755		

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F 755	Continued From page 18 not work properly and could have resulted in a serious outcome. LPN-B verified after R2 was discharged from the hospital ER the son picked up the prescription of potassium at another pharmacy. During an interview on 10/10/24 at 4:30 p.m. administrator stated staff would be expected to follow-up with pharmacy when R2's potassium was not available. Administrator stated would have been concerning when R2 missed 10 doses of potassium, provider should have been notified and asked what he would have liked them to do and provided direction. Administrator verified she thought most of the nurses had been provided education, unsure as to how many, DON would have kept track of that. Administrator stated planned meetings with pharmacy and completion of random audits. During an interview on 10/10/24 at 4:35 p.m. LPN-C stated R2's potassium was not delivered to the facility and was unable to administer for two shifts. LPN-C stated she had faxed pharmacy on 10/5/24 and received no response. LPN-C stated the potassium was not delivered by the 10/6/24, was unable to administer it for a second time in the a.m. LPN-C stated information was passed onto the oncoming shift. Facility policy Administering medications dated 4/2019, identified medication would be expected to be administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescribed orders to enhance optimal therapeutic effect of medication. Medication errors are documented, reported, and reviewed by QAPI (quality assurance performance improvement) committee to	F 755		

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F 755	Continued From page 19 informed process changes, or need for additional staff education. Facility policy Adverse Consequences and Medication Errors dated 2001, identified the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions and side effects. A medication error is defined as the preparation of drugs or biological which is not with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services. Example of a medication error: omission, a drug is ordered by not administered. A significant medication-related error was defined as hospitalization and required treatment with a prescription medication. In the event of a significant medication-related error or adverse consequence, take action as necessary, to protect the patient's safety and welfare. Provider should have been notified promptly of any significant error or adverse consequence. Communicate event to the oncoming shift as needed to alert staff for continued monitoring.	F 755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 696511

Dear Administrator:

The above facility was surveyed on October 9, 2024, through October 10, 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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
	00634	A. BUILDING: _____ B. WING _____	C 10/10/2024

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) COMPLETE DATE
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 10/9/24/24 and 10/10/24, 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		

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

Electronically Signed | 11/01/24

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53399421C (MN00107231, MN00107098) H53399449C (MN00107305, MN00107311) with a licensing order issued at 0265. 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	2 000		

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2 000	Continued From page 2 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. 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for	2 265		11/21/24

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2 265	Continued From page 3 example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to contact the resident's physician of missed administration of medication for 1 of 1 resident (R2) reviewed for medication errors. The missed administration of medication resulted in a critical low potassium level of 2.4 mmol/L (millimoles per liter) (normal range 3.5 - 5.1 mmol/L). Findings include: R2's progress note dated 9/30/24 at 4:15 a.m. indicated on-call provider notified R2 had increased edema 3+ bilateral extremities (BLE) and increased pain. R2 had been admitted from hospital on 9/27/24 and discontinued diuretic Bumetanide (Bumex). Pain to BLE was 7/10 and edema 3+ from toes to knees. Ordered received administer Lasix (diuretic) 20 milligrams (mg) now and follow up with primary care provider (PCP) in morning. R2's progress note dated 10/1/24 at 1:14 p.m., seen by primary care provider (PCP) today on rounds. Add Bumex 2 milligrams (mg) daily for edema, weight daily for two week and check labs on Thursday, 10/3/24.	2 265	Plan of correction for F755 Services/procedures/pharmacist/records 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: : R1 has received her potassium per MD order on 10/8/2024. Potassium rechecked on 10/10/2024 potassium 3.2 returning to normal limits. Resident discharged to her home on 10/25/2024 in stable condition 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice. : Nurse managers will complete an audit of all residents Monday thru Friday with missed medication documented on MAR. Daily review in IDT stand up Monday thru Friday for follow up on the reason for missed medication and interventions. Nurse managers are reviewing progress notes to assure MD is notified with change of condition, missed or refused medication. 3. The measures the facility will take or	

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2 265	Continued From page 4 R2's medication order start date 10/2/24 indicated Bumex oral tablet 2 mg by mouth one time a day related to edema. Order start date 10/2/24 and discontinued 10/8/24. R1's Electronic Medication Administration Record (EMAR) identified start date 10/2/24, and end date 10/8/24. Bumex oral tablet 2 mg, given by mouth one time a day related to edema was administered daily in morning on 10/2/24 through 10/8/24. R2's lab results dated 10/3/24 at 8:49 a.m. indicated potassium 2.8 mmol/L as low. The lab results were reviewed and acknowledged by physician assistant certified (PAC). R2's order dated 10/3/24 at 10:32 a.m., indicated start potassium 20 milliequivalents (mEq) twice daily, recheck basic metabolic panel (BMP) (measures calcium, carbon dioxide Chloride, Creatinine, glucose, potassium, sodium, blood urea nitrogen, to test body's kidney function) on Tuesday 10/8/24. Give 20 mEq by mouth two times a day related to hypokalemia. Order start date 10/3/24. Addressed on nursing home rounds. R2's progress note dated 10/3/24 at 8:28 p.m. indicated Orders-Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 (mEq) by mouth two times a day related to hypokalemia. Waiting on pharmacy. R1's Electronic Medication Administration Record (EMAR) identified start date 10/3/24, potassium chloride ER oral tablet 20 mEq by mouth two times a day related to hypokalemia. Potassium was signed off with a code #2 indicating not available from 10/3/24 at bedtime through 10/8/24	2 265	systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not recur: All staff nurses have been in serviced on the facility s Notification of Resident Change in Condition policy and promptly notifying a resident s representative of changes in condition and documenting the notification in the progress notes. All staff re-educated on policy of documentation of medication administration and medication administration. Guardian Pharmacy in serviced Nursing staff on “How to Prevent Medication Errors.” Facility is meeting with pharmacy in November to improve communication. Implementation of texting GNote and Web Connect portal in process. 4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent: 10/12/2024 daily monitoring Monday thru Friday for 4 weeks. Reviewing the EMAR for any missed medication, documentation and provider notification. Audits will be reviewed at monthly QAPI on November 21st to determine if additional auditing is necessary. The administer, director of nursing and designee will ensure compliance.	

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2 265	Continued From page 5 in the morning. R2 missed 10 doses. Potassium was signed off as given from 10/8/24, at bedtime through 10/10/24, in the morning. R2's admission Minimum Data Set (MDS) dated 10/4/2, identified R1 had intact cognition. R2's diagnoses included: cardiorespiratory conditions, pneumonia, and took a diuretic (removed fluid). R2's progress note dated 10/4/24 at 9:33 a.m. Orders - Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. No supply. R2's progress note dated 10/4/24 at 4:41 p.m. Orders - Administration Note: Orders: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available R2's progress note dated 10/5/24 at 6:52 p.m., Orders - Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available - pharmacy faxed. R2's progress note dated 10/6/24 at 6:00 p.m. Administration Note: Potassium Chloride ER Oral Tablet Extended Release 20 mEq by mouth two times a day related to hypokalemia. Medication not available. R2's potassium lab results 10/8/24 at 8:23 am., potassium 2.4 mmol/L low critical. R2's progress note dated 10/8/24 at 9:24 a.m. EMS called per provider's order due to low potassium level of 2.4 mmol/L. Currently waiting for arrival.	2 265		

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2 265	Continued From page 6 R2's progress note dated 10/8/2024 at 3:30 p.m. Incident Note: Provider and son updated on missed medication administration of Potassium doses missed on 10/3/24, evening up to today 10/8/24. During an interview on 10/10/24 at 9:10 a.m. licensed practical nurse (LPN)-A verified code number two entered in EMAR indicated medication was not available. LPN-A stated staff were expected to contact the provider after a medication error was made. During an interview on 10/10/24 at 12:30 p.m. R2's primary provider/medical doctor (MD)-A stated R2 was started on Bumex due to edema/swelling identified in lower extremities, and potassium level was to be rechecked on 10/3/24. MD-A stated R2's potassium level on 10/3/24 had dropped to 2.8 mmol/L and was started on potassium 20 mEq two times a day and recheck potassium level on Tuesday (five days later). MD-A stated he was informed on 10/8/24, R2 had not received the ordered potassium. MD-A stated would have expected staff to have contacted provider when it was discovered potassium had not been available. MD-A stated he was notified the potassium was not administered and first communication with him from staff was on 10/8/24. MD-A verified a low potassium would be concerning due the possibility of causing heart arrhythmia's (heart does not beat right, work correctly due to weak muscles and nerves caused by low potassium levels). During an interview on 10/10/24 at 1:30 p.m. floor manager/registered nurse (RN-B) stated when orders were received after rounds, they are	2 265		

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2 265	Continued From page 7 entered into the system by medical record, then verified by the unit manager. RN-B stated R2's potassium was not received the evening on 10/3/24, and typically would wait until the next day and for what every reason it got missed. RN-B stated R2's potassium level was low at 2.4 mmol/L on 10/8/24, concerning, and should have been maintained within normal ranges to keep the body running. RN-B stated R2's trip to ER could have been prevented. RN-B stated she expected staff to have contacted the provider when a mediation error occurred and/or unable to administer the ordered mediation for further guidance/direction. During an interview on 10/10/24 at 3:34 p.m. LPN-B stated R2's potassium was low on 10/3/24 and ordered placed to start R2 on potassium. LPN-B stated R1 had not received the ordered potassium from 10/3/24, through 10/8/24, a.m. (10 doses) and was very concerning. LPN-B indicated when potassium levels were critical it would be a cardiac thing, heart does not work properly, could have resulted in a serious outcome, and provider should have been contacted regarding the medication error. During an interview on 10/10/24 at 4:15 p.m. LPN-C stated R2's potassium was not available to administer on two-day shifts (10/5/24 and 10/6/24) she had worked. LPN-C stated a fax was sent to pharmacy on 10/5/24, and they never responded. LPN-C stated the potassium was not at the facility the following day either was unaware the provider should have been contacted. LPN-C stated she had passed this information onto the oncoming shift. LPN-C stated R2's potassium level was low, and a provider should have been called for additional orders.	2 265		

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2 265	Continued From page 8 Facility policy Adverse Consequences and Medication Errors dated 2001, identified the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions and side effects. A medication error is defined as the preparation of drugs or biological which is not with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services. Example of a medication error: omission, a drug is ordered by not administered. A significant medication-related error was defined as hospitalization and required treatment with a prescription medication. In the event of a significant medication-related error or adverse consequence, take action as necessary, to protect the patient's safety and welfare. Provider should have been notified promptly of any significant error or adverse consequence. Communicate event to the oncoming shift as needed to alert staff for continued monitoring. Facility policy Change in Resident's Condition or Status dated 2021, identified a significant change in condition was a major decline or improvement in resident's status that without intervention by staff or implementing standard disease-related interventions (is not "self-limiting") and/or ultimately based on judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. Except in medical emergencies, notifications will be made within twenty-four hours of a change in the resident's medical condition or status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the physician/nurse	2 265		

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2 265	Continued From page 9 practitioner is notified of condition changes as appropriate. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 265		