DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 16, 2021

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

RE: CCN: 245339
Cycle Start Date: October 14, 2020

Revised Letter

This letter revises and replaces the previous letter dated February 9, 2021 to correct the date of compliance, denial of payment remedy, and NATCEP loss. Denial of payment did not go into effect.

Dear Administrator:

On December 1, 2020, we notified you a remedy was imposed. On February 3, 2021 the Minnesota Department(s) of Health 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 December 30, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 31, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 25, 2020, 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), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 31, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 30, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 8, 2021

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

RE: CCN: 245339
Cycle Start Date: October 14, 2020

Dear Administrator:

On December 1, 2020, we notified you a remedy was imposed. On February 3, 2021 the Minnesota Department(s) of Health 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 February 3, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 31, 2020 be discontinued as of February 3, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 1, 2020, 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), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 31, 2020. 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 2, 2020

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

RE: CCN: 245339
Cycle Start Date: October 14, 2020

Dear Administrator:

On October 14, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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 14, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 14, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 10/14/2020

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 10/13/20, and 10/14/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints was found to be substantiated: H5339021C. Deficiency was issued at F610. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		11/25/20

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

Electronically Signed | 11/11/2020

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 610	Continued From page 1 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to thoroughly investigate allegations of employee to resident physical and verbal abuse for 1 of 1 resident (R1) reviewed for abuse. Findings include: R1's Face Sheet undated, indicated R1's diagnoses included Alzheimer's, delirium, panic disorder, psychomotor agitation (feeling of anxious restlessness that causes a person to make movements without meaning to), and dementia with behavioral disturbances. R1's care plan revision date 8/14/20, indicated R1 had aggressive behaviors towards staff, and other residents. R1 would grab, pinch, bite, kick, and attempt to hit. The care plan directed staff to explain step by step before providing cares, change staff if behaviors occurred, and remove R1 from situations that involved other residents. R1's quarterly Minimum Data Set (MDS) dated 7/28/20, indicated R1 was moderately cognitively impaired, and required extensive assistance with bed mobility, transfers, dressing, toileting, and	F 610	F-610 The Nursing Assistant, (NA-B), that was accused of physically kicking a resident was reported by the facility to the State Agency Incident Tracking ID # 338151, for both verbally and physically abusing a resident. Although the Nursing Assistant was immediately removed from the schedule and, after further investigation, was terminated from employment, and then reported onto the Nursing Assistant Registry and Police were contacted, the report was not submitted to the State Agency within the 2 hour regulation time period from when the first report was made. To prevent this type of incident from recurring in the future, an additional review of the Abuse Prevention and Vulnerable Adult Procedure was distributed for all staff to read, review, and sign, to acknowledge an understanding of the Abuse Prevention and Vulnerable Adult Policy and Procedure and the need to submit report to the State Agency within	

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F 610	Continued From page 2 personal hygiene. The incident tracking ID 338151 submitted to the State Agency (SA) on 10/7/20, at 10:31 p.m. indicated nursing assistant (NA)-A witnessed R1 kicking NA-B. NA-B told R1 "If you don't quit kicking me, I'm going to kick you." NA-A witnessed NA-B kick R1. The 5 day incident report submitted to the SA on 10/12/20, at 6:26 p.m. indicated after camera footage was reviewed from the time of the incident, it was determined NA-B verbally threatened R1, physically kicked R1, and poked R1 in the nose with NA-B's finger. R1's was interviewed and due to R1's dementia, R1 could not recall the incident. NA-B was terminated and reported to the Nursing Assistant Registry (NAR). On 10/13/20, at 3:58 p.m. the director of nursing (DON) stated NA-B was removed from the schedule right away, and was terminated after the assistant director of nursing (ADON) watched the video camera footage from the date of the incident. The DON further stated NA-B was reported to the NAR and the police were contacted. On 10/14/20, at 10:54 a.m. NA-A stated she worked from 4:00 p.m. to 9:00 p.m. on 10/7/20, the day she witnessed the abuse. NA-A stated she was sitting at the nurses desk station charting, and R1 was sitting on the other side of the nurse's desk in her wheelchair resting. NA-A stated NA-B came to the nurse's station desk and sat next to NA-A chart. NA-A stated she witnessed R1 kicking NA-B in the knee under the nurse's station desk. NA-A stated NA-B looked right at R1 and stated, "If you kick me one more	F 610	the 2 hour time period. All staff have been, and will continue to be, educated on the Abuse Prevention and Vulnerable Adult policy and procedure, through the Healthcare Academy on an annual basis. All staff began to complete the review and acknowledgement of the Abuse Prevention and Vulnerable Adult Policy Procedure on 10/13/2020, with date for all remaining staff to have completed and signed the Abuse Prevention and Vulnerable Adult Policy Procedure by 11/25/2020. Beginning on 10/13/2020, those staff who witnessed this incident or were working at time this incident occurred, were immediately re-educated to the appropriate procedure of timely reporting of any and all suspected or real abuse. Ongoing from 10/13/2020, Performance will be monitored by the Director of Nursing and/or the Assistant Director of Nursing, by reviewing the time frames of each Vulnerable Adult incident submitted by the facility and comparing it to the time that the report was initially reported within the facility. This will be completed on every potential abuse report, to ensure that the report was submitted within 2 hours of the incident being reported. Additionally, as part of completing a thorough investigation, interviews will be conducted on any staff aware of the incident and by interviewing any other staff working on the floor, at the time of an	

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F 610	Continued From page 3 time, I will kick you back." NA-A stated R1 continued to kick NA-B, and NA-B kicked R1, stood up and leaned over the desk, and poked R1 in the nose with her pointer finger. NA-B then pushed R1's wheelchair back from the desk with NA-B's foot, and NA-B walked away. On 10/14/20, at 2:59 p.m. the assistant director of nursing (ADON) stated when the abuse was reported to her, she filed a report to the state agency, called the facility, and had NA-B removed from the schedule pending facility investigation. ADON stated she watched the camera footage the next day, which confirmed physical abuse occurred by NA-B. The ADON stated NA-B was terminated 10/8/20, and the ADON proceeded and completed the investigation. The ADON stated she did not interview other residents or staff as a part of the investigation. The ADON stated a thorough investigation normally would include additional interviews with residents and staff, and thought since NA-B was terminated the day after the incident, there was no longer a concern. The policy Mother of Mercy Abuse Prevention and Vulnerable Adult Procedure dated 10/18/19, lacked direction on completing a thorough investigation. On 10/14/20, at 3:48 p.m. the DON stated part of an investigation would include interviews with other residents and staff. The DON stated additional staff and residents were not interviewed because NA-B was terminated the next day, and further stated the abuse that occurred was an isolated incident. The DON verified the facilities policy Abuse Prevention and Vulnerable Adult Procedure policy lacked	F 610	incident of actual or potential abuse taking place. To ensure ongoing compliance, this investigative process will be monitored by the Director of Nursing and Assistant Director of Nursing.	

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F 610	Continued From page 4 direction on conducting a thorough investigation. On 10/14/20, at 4:05 p.m. registered nurse (RN) -A stated she just updated the Abuse Prevention and Vulnerable Adult Procedure and provided a copy. RN-A verified prior to the update, the previous policy lacked direction on conducing a thorough investigation. The facility policy, Mother of Mercy Abuse Prevention and Vulnerable Adult Procedure updated 10/14/20, directed when completing an investigation, interview witness or persons that may have information concerning the incident, and document the statement.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 2, 2020

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

Re: Event ID: 75OI11

Dear Administrator:

The above facility survey was completed on October 14, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On dates 10/13/20, and 10/14/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found NOT to be in compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED: H5339021C. No Licesning	2 000		

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

Electronically Signed | 11/11/20

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2 000	Continued From page 1 orders were issued The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		