STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER: Mother of Mercy Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 230 Church Avenue, Box 676 Albany, MN 56307	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 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 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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Mother of Mercy Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Church Avenue, Box 676 Albany, MN 56307	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE], 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. 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Mother of Mercy Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Church Avenue, Box 676 Albany, MN 56307	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 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: 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 [DATE], 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. 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 10/8/24 arrived at 10:39 a.m., identified [AGE] 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 common for a [AGE] 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). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Mother of Mercy Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Church Avenue, Box 676 Albany, MN 56307	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.