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	12/20/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645 Based on interview and document review, the facility failed to ensure changes in medication were communicated to 1 of 1 residents (R33) reviewed for notification of change in medications. Findings include: R33's significant change Minimum Data Set (MDS) dated [DATE], indicated diagnoses included dementia, chronic diastolic congestive heart failure (CHF), atrial fibrillation (irregular heartbeat), peripheral neuropathy (nerve damage), and diabetes. R33's cardiology clinic note dated 2/28/24, indicated R33 presented with family member (FM)-B for a cardiology provider visit on 2/26/24. R33 had CHF with noted congestion in lungs and reported occasional shortness of breath and lower extremity edema. R33 needed to follow up with the cardiologist in one year, or sooner as needed. On 2/26/24, the cardiologist ordered furosemide (Lasix) 20mg daily as needed (PRN) for lung congestion and/or lower extremity edema related to CHF. R33's progress note dated 3/26/24 at 3:24 p.m., indicated Pharmacist recommendation of PRN Lasix 20 mg to give for 'lung congestion or edema'. If it is to continue, please add specific parameters for when to administer Lasix 20 mg QD PRN. i.e give for 5# weight gain in a week, 3# in a day, or give for 3+ BLE (Bilateral Lower Extremity), etc. This was reviewed and agreed to by PA. However, the progress note did not indicate what the provider agreed upon. R33's medication administration record (MAR) dated March 2024, indicated R33's furosemide 20mg daily PRN for lung congestion and/or lower extremity edema was discontinued on 3/26/24. However, R33's chart lacked evidence R33's representative had been notified of the change in medication. On 12/18/24 at 9:46 a.m., FM-B stated she brought R33 to the cardiologist in February of 2024 and a PRN order for Lasix was provided for lower extremity edema related to CHF. On 12/12/24, FM-B brought R33 for a prosthetic diagnostic fitting. Because R33 experienced an increase in edema, they were unable to apply the prosthetic. Upon return to facility, FM-B inquired about the PRN Lasix. The director of nursing (DON) informed FM-B the PRN Lasix had been discontinued on 3/26/24. FM-B stated the facility had not notified her of this medication change nor would not have agreed to discontinue the Lasix (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 at 4:18 p.m., DON confirmed progress notes failed to indicate R33's family had been notified the PRN Lasix had been discontinued. DON stated FM-B should have been made aware of the change to medications. It was important to communicate medication changes to residents and their family to ensure coordination of care. The facility's Change in a Resident's Condition or Status Policy, revised 2/2021, indicated the facility would promptly notify the resident/representative of any changes in medical care or nursing treatments.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657 Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 24 residents (R13) reviewed for advanced directives. Findings include: R13's admission Minimum Data Set (MDS) dated [DATE], indicated R13 admitted [DATE], was moderately cognitively impaired and had the following diagnoses: hypertension (HTN) (high blood pressure), arthritis, osteoporosis (bones becomes weak and brittle), and asthma. R13's Provider Orders for Life-Sustaining Treatment (POLST) dated 10/17/24, indicated R13's resuscitation wishes were Do Not Attempt Resuscitation/DNR. The document was signed by R13's Heath care agent, and the Physician's assistant. On 12/16/24 R13's resuscitation status in the electronic medical record (EMR) banner was FULL CODE. On 12/16/24 at 12:12 p.m., the registered nurse manager (RN)-D stated upon admission the nurse would review resuscitation options with the resident or family member, fill out the paper form and have the resident or family member sign off. The physician would review and sign, then the facility would upload it to the EMR. RN-D stated in an instance where they found someone unresponsive, staff would call for help, check the banner in the EMR, and proceed with the residents wishes. RN-D reviewed R13's current code status and stated R13 was a full code, RN-D checked R13's POLST. RN-D stated the orders and the POLST did not match. RN-D got up, and left. RN-D returned shortly and stated if the instance of finding orders that do not match, they would clarify them immediately as she just had done and updated the resident's medical record. RN-D stated when checking a resuscitation status, staff would always check the banner of the EMR, and then verify with the POLST. On 12/16/24 at 1:21 p.m., the director of nursing (DON) expected resuscitation orders were reviewed by the nurse upon admission, with the resident or resident family. A POLST form was initiated and a provider signed off. The DON stated their expectation if a resident was found unresponsive, was the staff would review the code status on the EMR banner and verify with the POLST. The DON confirmed the EMR banner and POLST form did not match prior to survey start on 12/16/24. In this instance the DON's expectation was staff would verify the order and update when/if needed, and the POLST was the most current information On 12/19/24, R13's EMR indicated a physician order for Full Code dated 10/16/24 and discontinued on 12/16/24. Physician order for DNR dated 12/16/24 and care plan was revised to include DNR on 12/17/24. Changes to the EMR were noted to have been made after survey entrance. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advanced directive policy dated 2001, indicated if the resident or representative indicates the resident does not have an established advance directive, the facility will offer assistance in establishing advanced directives.

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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** 44645 Based on interview and document review, the facility failed to notify and consult provider for 2 of 2 residents (R33, R43) reviewed for heart failure monitoring. Findings include: R33's significant change Minimum Data Set (MDS) dated [DATE], indicated diagnoses included dementia, chronic diastolic congestive heart failure (CHF), atrial fibrillation (irregular heartbeat), peripheral neuropathy (nerve damage), and diabetes. R33's Physician Fax Order Form dated 12/4/24, indicated an order for Lasix (a diuretic) 20mg daily as needed (PRN) for 3-pound (lb.) gain in a day or 5-lb. gain in a week. R33's weight summary and/or treatment administration record (TAR), printed 12/18/24, indicated the following daily weights from 12/5/24 to 12/18/24: 12/18 - 212 12/17 - no weight indicated 12/16 - 214.5 12/15 - 211 12/14 - 211 12/13 - 211.5 12/12 - 211 12/11 - 212 12/10 - no weight indicated 12/9 - 212 12/8 - 208 12/7 - 211 12/6 - 211 12/5 - 210.5 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's weight summary and/or TAR, printed 12/18/24, indicated R33 had a 3.5-lbs weight gain from 12/15/24 to 12/16/24 and a 4-lbs weight gain from 12/8/24 to 12/9/24 R33's medication administration record (MAR), printed 12/18/24, indicated Lasix 20mg daily PRN had not been administered 12/16/14 or 12/9/24 as ordered for weight gain. On 12/19/24 at 2:20 p.m., registered nurse (RN)-A confirmed R33 had an order for daily weights and to give Lasix 20mg daily PRN for 3-lb gain in a day or 5-lb. gain in a week. RN-A confirmed Lasix 20mg had not been administered to R33 on 12/16/24 nor 12/9/24 as ordered. R43's quarterly minimum data set (MDS) dated [DATE] indicated R43 was admitted to facility on 8/8/23 and had the following diagnoses: acute on chronic congestive heart failure, hypertensive heart disease with heart failure, history of transient ischemic attack and cerebral infarct. The MDS further indicated R43 was cognitively intact. R43's care plan with a last review date of 6/19/24 indicated a focus area of alteration in cardiac status related to diagnosis of hypertension (high pressure in the arteries that carry blood from the heart to the rest of the body), congestive heart failure (CHF)(a progressive disease that affects pumping action of the heart muscles), angina (a condition characterized by chest pain due to insufficient oxygen-rich blood reaching the heart muscle), atrial fibrillation (an irregular and often fast heartbeat) and deep vein thrombosis (a blood clot in a deep vein). Interventions included: administer oxygen as ordered; appointments with cardiology as directed; observe for signs and symptoms of CHF exacerbation including not limited to edema, shortness of breath, weight gain, adventitious lung sounds, cough, decreased oxygen saturations, weakness, increased heart rate, distended neck veins. The care plan indicated obtain weights as directed and update MD as ordered. An order summary dated 11/20/24 indicated R43 had an order for furosemide oral tablet 20 mg twice daily related to acute on chronic congestive heart failure. The bottom of the document had a handwritten provider note indicating the following: D/C Lasix (furosemide); Bumex 1mg BID; Labs-TSH, BNP, BMP in 1.5 weeks. Weights MWF. DX: CHF. An unsigned order summary dated 12/20/24 indicated an order for Bumex 1mg tablet -give Bumex 1mg by mouth in the afternoon related to acute on chronic congestive heart failure, and Bumex 1mg tablet-give Bumex 2mg by mouth in the morning for acute on chronic congestive heart failure. The order summary lacked a documented order for weights to be obtained on Monday, Wednesday and Friday as ordered on 11/20/24. Review of R43's documented weights indicated between 8/2/2024 through 8/30/24 seven out of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 9/2/24 through 9/30/24 eight of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 10/2/24 through 10/30/24 seven of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R43's documented weights indicated between 11/1/24 through 11/29/24 nine of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 11/18/24 indicated R43 told provider she felt like she was gaining water weight and her legs felt tighter than usual. The note went on to indicate R43's weight had increased from 261. 5 on 11/1 to 265.5 on 11/11 to 268.5 on 11/18. The progress note confirmed R43's order to check weights MWF but were not getting done consistently. Physician progress note dated 11/24/24 indicated resident had a history of heart failure and had been seen a few times earlier in 2024 for the same issue. The note indicated R43's baseline weight was around 245 to 250 pounds, but she had been experiencing a gradual increase over the past few months. Review of R43's documented weights indicated between 12/2/24 through 12/16/24 three of seven opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 12/3/24 indicated R43 reported to the provider her weight was recorded once during week, despite being scheduled for weigh-in on Monday, Wednesday, and Friday. The provider indicated ongoing concerns and despite orders for weights 3 times weekly, nursing staff had only completed once weekly. During interview on 12/20/2024 at 4:11 p.m., director of nursing (DON) confirmed R43 had an order for weights three times weekly on Monday, Wednesday, and Friday. DON stated nursing staff is responsible for obtaining, documenting, and communicating any concerns for residents with an order for scheduled weights. DON stated if a scheduled weight was not performed the nursing staff should notify the physician. Further, DON confirmed R33 had not received PRN Lasix on 12/16/24 nor 12/9/24, as indicated by R33's weight gain. DON stated nurses were expected to administer the Lasix 20mg PRN if R33 had a weight gain that met the physician ordered parameters. DON further stated if a weight had been missed, nurses were expected to reach out to the provider to notify and request direction. DON stated this process was important for maintaining resident health and to avoid an acute episode of heart failure. The facility's Change in a Resident's Condition or Status Policy, revised 2/2021, indicated the facility promptly notified the resident attending physician of changes in resident's medical/mental condition and/or status. 49654 Findings include:

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645 Based on interview and document review, the facility failed to provide a written notice of a bed-hold at the time of transfer for two hospitalization s for 1 of 2 residents (R33) reviewed for hospitalization . Findings include: R33's significant change Minimum Data Set (MDS) dated [DATE], indicated diagnoses included dementia, chronic diastolic congestive heart failure (CHF), atrial fibrillation (irregular heartbeat), peripheral neuropathy (nerve damage), and diabetes. R33's progress note dated 8/14/24 at 12:52 p.m., indicated R33 was transferred via ambulance to the hospital for increased redness and swelling in the left foot, and a verbal bed-hold was received from FM-B. R33's progress note dated 8/14/24 at 6:20 p.m., indicated R33 was admitted to the hospital for intravenous (IV) antibiotic treatment. A subsequent progress noted dated 8/20/24 at 11:57 p.m., indicated R33 returned from the hospital. R33's Bed-hold Policy form, dated 8/14/24, indicated a bed-hold telephone consent was obtained verbally from R33's family member (FM)-B. The form was signed and dated by the registered nurse (RN) on 8/14/24. However, R33's record lacked evidence a written bed-hold notice was received by the resident/representative at the time of transfer. R33's progress note dated 12/18/24 at 11:57 p.m., indicated R33 was transferred via ambulance to the hospital for increased pain and change in transfers, a verbal bed-hold from the POA (power of attorney) was noted, and orders/MAR were sent. R33's progress note dated 12/19/24 at 5:06 a.m., indicated R33 was admitted to the hospital Telemetry unit for congestive heart failure (CHF) and possible hip fracture. On 12/19/24 at 8:23 a.m., FM-B stated she gave a verbal consent for a bed-hold on 12/18/24. FM-B stated the family had questions regarding the policy and potential costs but had not received a written copy from the facility, nor was a copy sent with R33's information provided by the facility for the hospital at the time of transfer. On 12/20/24 at 10:56 a.m., social services designee (SS)-A, stated the nurses were trained to review the Bed-hold Policy with the resident/responsible party at the time of transfer, and obtain verbal consent or a signature on the form. A copy of evidence a written bed-hold notice was received by the resident/representative at the time of transfer for 8/14/24 was requested. However, SS-A only provided a copy of the telephone consent from 8/14/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 at 4:18 p.m., director of nursing (DON) verified evidence a written bed-hold notice was received by the resident/representative at the time of transfer for 8/14/24 and 12/18/24 were not stated written bed-hold information needed to be provided at the time of transfer, or with 24 hours for emergent transfers. The DON expected staff to have the Bed-hold Policy signed by the resident/representative at the time of transfer or send a copy of the Bed-hold Policy with the resident at the time of transfer. If a signature was not obtained by the resident/representative at the time of transfer, the DON expected social services (SS) or the nurse manager to follow-up until a signed form was obtained. DON stated written bed-hold information was important, so residents/representatives understood their rights and what a bed-hold entailed. On 12/23/24 at 5:18 p.m., the facility provided a copy of R33's Therapeutic Leave of Absence Day (Bed-hold Policy) form which indicated a bed-hold telephone consent was obtained from R33's family member (FM)-B. The form was signed and dated by the registered nurse (RN) on 12/18/24. However, R33's record lacked evidence a written bed-hold notice was received by the resident/representative at the time of transfer. The facility's Bed-Holds and Returns Policy, revised 10/2022, indicated residents/representatives were provided written information regarding the bed-hold policies, which addressed holding or reserving a resident's bed during periods of absence at the time of transfer or, if the transfer was an emergency, within 24 hours.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and document review, the facility failed to complete and transmit a discharge return not anticipated Minimum Data Set (MDS) for 2 of 2 residents (R25, R48) reviewed for transmission of resident assessment. Findings include: R25's significant change MDS dated [DATE], included an admitted [DATE]. R25 was cognitively intact with a primary diagnosis of osteoarthritis of the right hip (the tissue of the joint breaks down over time) with joint replacement. R25's facility assessment titled Post Discharge Plan of Care dated 6/21/24, included a discharge date of [DATE]. Assessment included R25 participated in the discharge plan. R25's medical record lacked evidence a discharge MDS was completed. R48's admission MDS dated [DATE], included an admitted [DATE]. R48 was cognitively intact with a primary diagnosis of hyponatremia (low sodium level). R48's progress note dated 9/5/24, included R48 left the facility and stated she would not be returning. Facility noted a Minnesota Adult Abuse Reporting Center (MAARC) report was filed. R48's progress noted dated 9/6/24, included R48 returned to the facility to collect belongings and medication. R48's medical record lacked evidence a discharge MDS was completed. During interview on 12/20/24 at 11:21 a.m., MDS registered nurse (RN)-A confirmed she completed MDS assessments for the facility. RN-A worked offsite and relied on the facility to update her when residents admitted , discharged , or had a significant change. RN-A confirmed a discharge MDS was not completed for both R25 and R48. RN-A thought this may have been due her not being updated on the discharge and noted young staff and frequent turn over of leadership. During interview on 12/20/24 at 2:23 p.m., director of nursing (DON) stated she had not had a lot to do with MDS completion and submission since she started in October. She stated there was a leadership email group that should be updated whenever someone was admitted , transferred to the hospital or discharged . The MDS nurse should have been on this email group and should have received updates. The DON stated it was important to submit complete and accurate MDS data in a timely manner to document and bill correctly. Policy for MDS submissions requested and not provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645 Based on interview and document review, the facility failed to revise the comprehensive care plan for 2 of 2 residents (R33, R43) reviewed for heart failure. Findings include: R33's significant change Minimum Data Set (MDS) dated [DATE], indicated R33 was admitted to facility on 9/15/23 and had the following diagnoses: chronic diastolic congestive heart failure (CHF), atrial fibrillation (A-Fib), chronic obstructive pulmonary disease (COPD), and diabetes. The MDS further indicated R33 was cognitively intact. R33's care plan with a last review date of 6/19/24, indicated a focus area of alteration in respiratory status related to diagnoses of COPD, sleep apnea, CHF, chronic bronchitis, and resident experienced shortness of breath (SOB) with exertion. Interventions were listed to administer medications/nebulizers as ordered and observe for effectiveness/side effects; observe for SOB, dyspnea (labored breathing), cyanosis (blue skin), change in mentation (mental function), anxiety, restlessness, air hunger, and document if these occurred; utilize CPAP per physician order. The care plan also listed an intervention of licensed nurse to observe skin weekly. Additionally, an intervention of daily weights was added on 12/12/24. R33's cardiology clinic note dated 2/28/24, indicated R33 presented with her family member (FM)-B for a cardiology provider visit on 2/26/24. R33 had CHF with noted congestion in lungs and reported occasional shortness of breath and lower extremity edema. The cardiologist ordered furosemide (Lasix - a diuretic) 20mg daily as needed (PRN) for lung congestion and/or lower extremity (LE) edema related to CHF. However, R33's record lacked evidence a nurse had contacted the cardiologist to obtain more specific parameters for the administration of a PRN diuretic. Additionally, R33's record lacked evidence measures were initiated to monitor R33 for lung congestion and LE edema. R33's order history, printed 12/18/24, indicated R33 had an order for furosemide oral tablet 20mg daily as needed for lung congestion and/or lower extremity edema was started on 2/28/24. However, R33's care plan had not been updated to include interventions to monitor for lung congestion and LE edema. R33's Hospital Orders Discharge Report dated 8/20/24, indicated R33 was hospitalized from 8/14/24 to 8/20/24. The discharge orders instructed facility staff to call the physician for weight gain of 3 pounds or more over night or gain 5 pounds in a week. However, R33's record lacked evidence the weight monitoring order had been transcribed and implemented. Additionally, R33's care plan had not been updated to include interventions to monitor for weight gain. R33's progress note dated 9/3/24 at 11:57 a.m., indicated R33 was seen on provider rounds and weights x 1 week was ordered. However, R33's care plan had not been updated to include interventions to monitor weights. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's PCP progress notes for 9/3/24, dated 9/4/24 at 8:10 a.m., indicated R33's Jardiance was to be discontinued to help with R33's urinary concerns, and because CHF was a chronic concern, nursing staff would monitor weights 3 times weekly, and if weight increased the provider would consider ordering a diuretic or restart a lower dose of Jardiance. However, R33's care plan had not been updated to include interventions to monitor weights or signs/symptoms of CHF exacerbation. R43's quarterly minimum data set (MDS) dated [DATE] indicated R43 was admitted to facility on 8/8/23 and had the following diagnoses: acute on chronic congestive heart failure, hypertensive heart disease with heart failure, history of transient ischemic attack and cerebral infarct. The MDS further indicated R43 was cognitively intact. R43's care plan with a last review date of 6/19/24 indicated a focus area of alteration in cardiac status related to diagnosis of hypertension (high pressure in the arteries that carry blood from the heart to the rest of the body), congestive heart failure (CHF) (a progressive disease that affects pumping action of the heart muscles), angina (a condition characterized by chest pain due to insufficient oxygen-rich blood reaching the heart muscle), atrial fibrillation (an irregular and often fast heartbeat) and deep vein thrombosis (a blood clot in a deep vein). Interventions were listed as administer oxygen as ordered; appointments with cardiology as directed; observe for signs and symptoms of CHF exacerbation including but not limited to edema, shortness of breath, weight gain, adventitious lung sounds, cough, decreased oxygen saturations, weakness, increased heart rate, distended neck veins. The care plan also listed an intervention of obtaining weights as directed and update MD as ordered. An order summary dated 11/20/24, indicated R43 had an order for furosemide oral tablet 20 mg twice daily related to acute on chronic congestive heart failure. The bottom of the document had a handwritten provider note indicating the following: D/C Lasix(furosemide); Bumex 1mg BID; Labs-TSH, BNP, BMP in 1.5 weeks. Weights MWF. DX: CHF. R43 physician note dated 11/21/24, indicated resident had 'a history of heart failure and had been seen a few times earlier this year for the same issue. Resident baseline weight was around 245 to 250 pounds, but she has been experiencing a gradual increase over the past few months. Her most recent weight, recorded three days ago, was 268 pounds. This morning, her weight was recorded as 265.5 pounds. Resident believed her weight gain is due to fluid retention, as her legs feel tight'. R43 physician note dated 12/3/24, indicated resident reported her weight was recorded once during week, despite being scheduled for weigh-in on Monday, Wednesday, and Friday. The provider indicated ongoing concerns and despite orders for weights 3 times weekly, nursing staff had only completed once weekly and weight was up to 268. During interview on 12/20/2024, at 4:11 p.m., director of nursing (DON) confirmed R33 had a history of CHF exacerbation and expected nurses to implement interventions to monitor weights and edema. Additionally, nurses were expected to review and update resident care plans when they review orders, provider notes, and hospital discharge orders. Further, DON stated R43 had an order for weights three times weekly on Monday, Wednesday, and Friday. DON also confirmed the order was not carried over to the care plan as written. DON stated nursing staff is responsible for creating the care plan based on assessments of each resident and physician's orders. DON stated this process was important for maintaining resident health and for staff to have a clear directive and plan to prevent an acute exacerbation of heart failure. (continued on next page)

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	245339	A. Building B. Wing	12/20/2024

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/20/24 at 4:18 p.m., director of nursing (DON) A policy was requested, but not provided. 49654

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44645 Based on interview and document review, the facility failed to monitor and implement interventions for heart failure for 2 of 2 residents (R33, R43) reviewed. This resulted in actual harm to R33 who was re-hospitalized on exacerbation of heart failure. Findings include: R33's significant change Minimum Data Set (MDS) dated [DATE], indicated R33's diagnoses included dementia, chronic diastolic congestive heart failure (CHF), diabetes, phantom limb pain (from below knee amputation), and cellulitis (bacterial infection) of left lower limb. R33's cardiology clinic note dated 2/28/24, indicated R33 presented with her family member (FM)-B for a cardiology provider visit on 2/26/24. R33 had CHF with noted congestion in lungs and reported occasional shortness of breath and lower extremity edema. The cardiologist ordered furosemide (Lasix - a diuretic) 20mg daily as needed (PRN) for lung congestion and/or lower extremity (LE) edema related to CHF. However, R33's record lacked evidence a nurse had contacted the cardiologist to obtain more specific parameters for the administration of a PRN diuretic. Additionally, R33's record lacked evidence measures were initiated to monitor R33 for lung congestion and LE edema. During interview on 12/20/24 at 4:18 p.m., director of nursing (DON) stated the nurse was expected to update R33's care plan to ensure R33 was monitored for lung congestion and edema to trigger the nurse to administer the PRN Lasix as ordered. Additionally, because R33 had a diagnosis of CHF, the nurse was expected to ensure R33 was monitored for edema and weight gain to prevent CHF exacerbation. R33's progress note, dated 3/13/24 at 12:35 a.m., indicated R33 had left lower extremity (LLE) 2+ edema (moderate pitting), and the area below and behind the knee was taut. However, R33's record lacked evidence the nurse administered Lasix 20mg daily PRN for LE edema as ordered. Additionally, the record lacked evidence the provider had been notified. R33's weight summary, printed 12/18/24, indicated R33's weight was 199 pounds (lb) on 3/15/24, and 205 lb on 3/22/24, which indicated a weight gain of 6 pounds in a week. However, R33's record lacked evidence R33 had been assessed for lung congestion and/or LE edema to determine if PRN Lasix was indicated. Additionally, the record lacked evidence the provider had been notified of the weight gain. R33's pharmacist (PharmD) recommendations to providers dated 3/21/24, indicated an order for 'PRN Lasix 20mg to give for lung congestion or edema' had vague parameters that could lead to inconsistencies in administration. PharmD indicated the PRN Lasix had not been used since ordered on 2/26/24, and suggested the provider consider either discontinuing the PRN Lasix; or if the provider wished to continue the PRN Lasix, the order needed to include specific parameters for when to administer (e.g. Give for 5-lb weight gain in a week, 3-lb weight gain in a day). Subsequently, on 3/26/24, R33's primary care provider (PCP) placed a check mark in the agree box and signed the document, but the provider had not indicated if the PRN Lasix was to be discontinued or if it was to be continued with specific parameters. Further, R33's record lacked evidence the nurse had contacted the PCP and/or the cardiologist to clarify the PharmD recommendations. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During interview on 12/20/24 at 4:18 p.m., DON acknowledged the provider's response to the PharmD recommendations dated 3/21/24 was unclear. DON verified PRN Lasix order had been discontinued by the nurse on 3/26/24. DON stated the PRN Lasix should not have been discontinued and the nurse should have contacted the provider to clarify the order. R33's medication administration record (MAR) dated March 2024, indicated R33's furosemide [Lasix] 20mg daily PRN for lung congestion and/or lower extremity edema was discontinued on 3/26/24. However, R33's chart lacked evidence of a signed physician order to discontinue Lasix 20mg daily PRN. R33's progress note dated 3/31/24 at 10:15 p.m., indicated R33's LLE had 3+ edema (deep pitting) and cracks on foot where swelling increased pressure. However, the nurse indicated will update provider on next doctor rounds. R33's record indicated the provider saw R33 on 4/4/24. R33's progress note dated late entry 4/12/24 at 10:05 a.m., indicated upon skin assessment resident found to have a few blood blisters on left shin. Current interventions included inspect skin PRN with cares, nurse to observe skin weekly, lift/do not slide resident, use assistive devices, and observe for signs/symptoms of infection and updated provider PRN. New intervention of lotion body daily PRN. However, R33's record lacked evidence the provider had been notified. R33's progress note dated 4/12/24 at 4:30 p.m., indicated two small blood blisters and two small opened blisters were found on R33's left calf, and occasional blistering of skin was related to edema. However, R33's record lacked evidence the provider had been notified. R33's progress note dated 4/16/24 at 3:30 p.m., indicated R33 was seen by the provider during rounds, and ordered increased bedtime (HS) dose of gabapentin (for pain), increase HS dose of Lyrica (for pain), and continue to monitor blood blisters on LLE. R33's weight summary for April 2024 through August 2024, indicated R33's weights were obtained 4/5/24, 4/12/24, 4/19/24, 5/10/24, 5/17/24, 6/1/24, 6/7/24, 6/14/24, 6/28/24, 7/5/24, 7/12/24, 7/19/24, 8/2/24, 8/9/24, and 8/26/24, with no significant weight gain noted. R33's order history, printed 12/18/24, indicated R33 received wound care for a right lower extremity (RLE) ulcer from 4/23/24 through 6/19/24, and an order for a wound clinic referral was placed 4/30/24. R33's progress note dated 8/12/24 at 5:21 a.m., indicated R33's 2nd, 3rd, and 4th toes on left foot were very red, not warm to touch, swollen, and R33 denied pain. However, R33's record lacked evidence the provider had been notified. R33's progress note dated 8/13/24 at 12:37 a.m., indicated R33 was noted to have bled through her sock and all R33's toes on left foot were swollen with dark purple discoloration extending to the top of R33's foot, with redness across top of foot. R33's 1st toe was largely swollen with the 2nd toe resting tightly against it. R33's 3rd toe was swollen to the point of skin breaking open on top of toe with peeling skin and resident cannot feel toes and cannot detect pain. The nurse indicated the unit manager was notified and R33 was added to provider rounds later that day. R33's progress note dated 8/13/24 at 12:58 a.m., indicated R33 had a 3cm x 3cm wound on the front of left calf and noted to have thick, purulent drainage (pus). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R33's progress note dated 8/13/24 at 12:56 p.m., indicated R33 was seen by the provider for her LLE. The provider ordered Keflex (antibiotic) 500mg three times a day (TID) for 7 days, MRI for left foot to check for deeper infection, and labs drawn 8/15/24. R33's progress note dated 8/14/24 at 12:52 p.m., indicated R33 was transferred to the ED for increased redness and swelling in left foot. A subsequent progress note dated 8/14/24 at 6:20 p.m., indicated R33 was admitted to the hospital. R33's Hospital Orders Discharge Report dated 8/20/24, indicated R33 was hospitalized from 8/14/24 to 8/20/24 for multiple open wounds of LLE. The discharge orders instructed facility staff to call the physician for weight gain of 3 pounds or more over night or gain 5 pounds in a week. However, R33's record lacked evidence the weight monitoring order had been transcribed and implemented. During interview on 12/20/24 at 4:18 p.m., DON verified the 8/20/24 hospital discharge order to monitor R33's weight had not been completed. DON stated the nurse was expected to identify and follow the hospital weight monitoring order. R33's primary care provider (PCP) progress notes, dated 8/22/24, indicated R33 had a history of right partial lower extremity amputation below the knee in 2020 due to osteomyelitis, and had recently been hospitalized due to a wound on R33's left lower leg. R33's progress note dated 9/3/24 at 11:57 a.m., indicated R33 was seen on provider rounds and weights x1 week was ordered. However, R33's record lacked evidence the nurse clarified the order to obtain specific parameters for when to notify the physician. R33's subsequent PCP progress notes for 9/3/24, dated 9/4/24 at 8:10 a.m., indicated nursing staff were to monitor R33's weights 3 times weekly, and if weight increased the PCP would look at as needed dosing of diuretics or reinstitution of lower dose of Jardiance. However, R33's record lacked evidence the nurse identified the conflicting weight orders of weights x1 week and weights 3 times weekly, and R33's record lacked evidence the conflicting weight orders were clarified with the provider. During interview on 12/20/24 at 4:18 p.m., DON acknowledged the PCP progress notes for 9/3/24 directing the nursing staff to monitor weights 3 times weekly had not been completed. DON stated the nurse was expected to review the PCP progress notes and to have entered the order to monitor R33's weights 3 times weekly. Additionally, DON stated the nurse was expected to contact the provider to clarify any order discrepancies and ensure specific parameters were in place. R33's order history indicated an order for daily weights one time a day for 1 week was started 9/4/24 and ended on 9/11/24. R33's weight summary indicated the following weights for 9/4/24 through 9/11/24: 9/4 - no documented weight 9/5 - 201 lb 9/6 - no documented weight 9/7 - 200 lb (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	9/8 - 199 lb 9/9 - no documented weight 9/10 - 206.5 lb - gain of 7.5 lb in 2 days 9/11 - no documented weight However, R33's record lacked evidence the provider was notified of the weight gain of 7.5 lb from 9/8/24 through 9/10/24. Additionally, the record lacked evidence the nurse notified the provider, weights had not been obtained on 9/4/24, 9/6/24, 9/9/24, and 9/11/24. R33's record lacked evidence the order for weights 3 times weekly, as indicated on the 9/3/24 PCP progress notes were entered and implemented. R33's weight summary indicated R33's weight was 204 lb on 9/23/24, and 209 lb on 9/27/24, which indicated a weight gain of 5 lb in 4 days. R33's record lacked evidence the provider had been notified. R33's weight summary indicated R33's weight was 206 lb on 10/22/24, and 213 lb on 10/24/24, which indicated a weight gain of 7 lb in 2 days. R33's record lacked evidence the provider had been notified. R33's weight summary indicated R33's weight was 206.5 lb on 10/28/24, and 209.5 lb on 10/29/24, which indicated a weight gain of 3 lb in 1 day. R33's record lacked evidence the provider had been notified. R33's PCP progress notes, dated 10/30/24, indicated R33's continued to have LLE sores that were secondary to chronic edema of the area. R33's PCP progress notes, dated 11/5/24, indicated R33's active diagnoses included CHF, and cellulitis of the LLE. The PCP progress note further indicated, Cardiology has recommended Lasix 20 mg if she experiences a 2-pound weight gain. However, R33's record lacked evidence a nurse notified the provider that R33 did not have a current order for Lasix. R33's orthopedic visit note, dated 11/7/24, indicated the lesion at the front of R33's left leg was a result of swelling into the leg. R33's weight summary indicated R33's weight was 206.5 lb on 11/18/24, and 211 lb on 11/19/24, which indicated a weight gain of 4.5 lb in 1 day. R33's record lacked evidence the provider had been notified. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During interview on 12/18/24 at 9:46 a.m., R33's family member (FM)-B stated a few weeks ago she spoke with the DON why R33 was not getting her PRN Lasix because she was concerned about the swelling in R33's legs. FM-B stated the DON told her the PRN Lasix had been discontinued on 3/26/24, and the DON later found the order had been discontinued based on a pharmacy recommendation. FM-B stated she had asked the cardiologist in February 2024 to prescribe something for R33's edema and thought R33 had been receiving the PRN Lasix since then. FM-B stated R33's family was concerned because R33 already had a leg amputated after her edema led to blisters and sores that became infected. FM-B stated she was concerned the same could happen to R33's LLE because the facility was not following physician orders. R33's Physician Fax Order, dated 12/4/24, indicated registered nurse (RN)-E requested an order for PRN Lasix as indicated on the cardiology clinic note dated 2/26/24, as R33 did not have the medication available, and family wanted it available. However, RN-E failed to provide any assessment information to support the request. On 12/5/24, R33's PCP subsequently wrote an order for Lasix 20mg daily PRN for 3 lb gain in a day or 5 lb gain in a week. During interview on 12/20/24 at 4:18 p.m., DON stated the 12/4/24 request to the provider for PRN Lasix was prompted after FM-B stated concern regarding R33's edema and asking why R33 was not receiving the PRN Lasix. DON stated after she determined the PRN Lasix had been discontinued on 3/26/24 and subsequently requested on order for PRN Lasix. Additionally, DON stated prior to FM-B bringing the concern to her, she absolutely would have expected a nurse to have identified the changes. R33's order history indicated an order for weight daily AM was started 11/28/24 and on 12/5/24, an order for Lasix 20mg every 24 hours as needed for edema; weight gain give if 3 lb gain in a day or 5 lb gain in a week was started. However, the nurse failed to ensure the weight daily AM order alerted the nurse of the specific parameters and PRN Lasix order. During interview on 12/20/24 at 4:18 p.m., DON stated the nurse was expected to have transcribed the order and/or verify the order to ensure the weight order was connected to the PRN Lasix order. R33's weight summary indicated the following weights for 12/5/24 to 12/18/24: 12/5 - 210.5 12/6 - 211 lb 12/7 - 211 lb 12/8 - 208 lb 12/9 - 212 lb 12/10 - no documented weight 12/11 - 212 lb 12/12 - 211 lb (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	12/13 - 211.5 lb 12/14 - 211 lb 12/15 - no documented weight 12/16 - 214.5 lb 12/17 - no documented weight 12/18 - 212 lb R33's weight summary indicated R33's weight was 208 lb on 12/8/24, and 212 lb on 12/9/24, which indicated a weight gain of 4 lb in 1 day. However, R33's MAR, dated December 2024, indicated PRN Lasix was not administered on 12/9/24 as ordered by the provider. During interview on 12/20/24 at 4:18 p.m., DON verified Lasix 20mg PRN had not been administered on 12/9/24. Additionally, DON verified R33 had a weight gain of 4 lbs in 1 day, from 12/8/24 to 12/9/24. DON stated the nurse was expected to administer the PRN Lasix because R33's weight gain met the parameters. R33's care plan, printed 12/18/24, indicated daily weight was initiated on 12/12/24. However, no information regarding the PRN Lasix was added to R33's care plan. R33's weight summary indicated R33's weight was 211 lb on 12/14/24, and 214.5 lb on 12/16/24, which indicated a weight gain of 3.5 lb in 2 days. However, R33's lacked evidence the nurse notified the provider R33's weight was not obtained on 12/15/24. During interview on 12/20/24 at 2:35 p.m., registered nurse (RN)-A verified she administered R33's medications on 12/16/24. RN-A stated R33's weight had not been taken on 12/15/24, so she looked at the weight from one week prior, and R33's weight on 12/9/24 was 212. RN-A stated she did not administer PRN Lasix to R33 on 12/16/24 because there was only a 2.5 lb gain in a week. RN-A stated the provider was not contacted for direction and the provider was not notified of the missed weight. Additionally, R33's record lacked evidence the nurse notified the provider R33's weights had not been obtained on 12/10/24 and 12/17/24. During interview on 12/20/24 at 4:18 p.m., DON stated the nurse was expected to reach out to the provider to notify weight missed and request advice. DON expected the nurse on the cart to ensure the daily weight was obtained. R33's progress note dated 12/19/24 at 12:18 a.m., indicated R33 had been admitted to the hospital telemetry unit for CHF, it was unclear if R33 had a hip fracture, but the hospital was dealing with the CHF at that time. R33's Hospital Emergency Department (ED) to Admission Notes, dated 12/19/24, indicated R33 presented to the ED on 12/18/24 with acute on chronic heart failure exacerbation, coming in for dieresis, and a fall injury. R33 was started on Lasix 40 mg intravenous (IV), with plan to increase as needed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/19/24 at 8:23 a.m., FM-B stated she was with R33 in the ED on 12/18/24. In the ED, R33's LLE was really swollen, red, and R33 was unable to straighten her leg. FM-B stated R33 was given Lasix IV in the ED and R33's weight went down as a result. On 12/20/24 at 9:10 a.m., FM-B stated R33's weight was down and it was visible in R33's face, legs, and belly. FM-B stated R33 was given scheduled Lasix and would discharge from the hospital with an order for scheduled Lasix. On 12/19/24 at 12:20 p.m., the provider stated Lasix 20mg daily PRN for 3 lb gain in a day or 5 lb gain in a week was ordered for R33, and the facility was expected to obtain daily weights for such an order. R33 should have received PRN Lasix on 12/9/24 because of a one-day 4 lb increase, and the provider should have been notified. The provider expected to be notified if a daily weight was missed, and he was not aware daily weights were missed on 12/10, 12/15, and 12/17. The provider stated if the order was not followed, it could cause fluid retention leading to heart failure, shortness of breath, and possible hospitalization . Provider acknowledged R33 was currently hospitalized and stated if the PRN Lasix was administered per the specific parameters, the need for dieresis could have been avoided. On 12/19/24 at 3:01 p.m., nursing assistant (NA)-B stated R33 had LE swelling that varied in severity, they are normal, then big, then in between, and NA-B notified the nurse whenever R33's legs were bigger than the prior day. On 12/20/24 at 4:18 p.m., DON verified R33 was currently hospitalized and was admitted with diagnosis of acute exacerbation of CHF and fracture of the femur. DON acknowledged the facility failed to monitor R33's weights and administer PRN Lasix as ordered, and stated Absolutely, the need to admit for exacerbation could have been avoided. R43's quarterly minimum data set (MDS) dated [DATE] indicated R43 was admitted to facility on 8/8/23 and had the following diagnoses: acute on chronic congestive heart failure, hypertensive heart disease with heart failure, history of transient ischemic attack and cerebral infarct. The MDS further indicated R43 was cognitively intact. An order summary dated 11/20/24 indicated R43 had an order for furosemide oral tablet 20 mg twice daily related to acute on chronic congestive heart failure. The bottom of the document had a handwritten provider note indicating the following: D/C Lasix (furosemide); Bumex 1mg BID; Labs-TSH, BNP, BMP in 1.5 weeks. Weights MWF. DX: CHF. An unsigned order summary dated 12/20/24 indicated an order for Bumex 1mg tablet -give Bumex 1mg by mouth in the afternoon related to acute on chronic congestive heart failure, and Bumex 1mg tablet-give Bumex 2 mg by mouth in the morning for acute on chronic congestive heart failure. The order summary lacked a documented order for weights to be obtained on Monday, Wednesday and Friday as ordered on 11/20/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R43's care plan with a last review date of 6/19/24 indicated a focus area of alteration in cardiac status related to diagnosis of hypertension (high pressure in the arteries that carry blood from the heart to the rest of the body), congestive heart failure (CHF) (a progressive disease that affects pumping action of the heart muscles), angina (a condition characterized by chest pain due to insufficient oxygen-rich blood reaching the heart muscle), atrial fibrillation (an irregular and often fast heartbeat) and deep vein thrombosis (a blood clot in a deep vein). Interventions included: administer oxygen as ordered; appointments with cardiology as directed; observe for signs and symptoms of CHF exacerbation including not limited to edema, shortness of breath, weight gain, adventitious lung sounds, cough, decreased oxygen saturations, weakness, increased heart rate, distended neck veins. The care plan also listed an intervention of obtaining weights as directed and update MD as ordered. Review of R43's documented weights indicated between 8/2/2024 through 8/30/24 seven out of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 9/2/24 through 9/30/24 eight of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 10/2/24 through 10/30/24 seven of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Review of R43's documented weights indicated between 11/1/24 through 11/29/24 nine of thirteen opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 11/18/24 indicated R43 told provider she felt like she was gaining water weight and her legs felt tighter than usual. The note went on to indicate the R43's weight had increased from 261.5 on 11/1 to 265.5 on 11/11 to 268.5 on 11/18. The progress note confirmed R43's order to check weights MWF but were not getting done consistently. Physician progress note dated 11/24/24 indicated resident had a history of heart failure and had been seen a few times earlier in 2024 for the same issue. The note indicated R43's baseline weight was around 245 to 250 pounds, but she had been experiencing a gradual increase over the past few months. Review of R43's documented weights indicated between 12/2/24 through 12/16/24 three of seven opportunities for weight were missed. The record lacked evidence of provider notification of the missed weights. Physician progress note dated 12/3/24 indicated R43 reported to the provider her weight was recorded once during week, despite being scheduled for weigh-in on Monday, Wednesday, and Friday. The provider indicated ongoing concerns and despite orders for weights 3 times weekly, nursing staff had only completed once weekly. (continued on next page)

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	245339	A. Building B. Wing	12/20/2024

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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F 0684 Level of Harm - Actual harm Residents Affected - Few	During observation and interview on 12/16/24 at 09:57 a.m., R43 had pitting edema (swelling caused by excess fluid in the body's tissues that leaves an indentation when pressed) in both lower extremities. R43 stated she took diuretics (a medication to help move excess fluid and salt out of the body) daily and was supposed to be weighed three times weekly on Monday, Wednesday, and Friday before breakfast. R43 stated she was frequently weighed only once per week despite orders from her physician to be weighed three times. During interview on 12/20/24 at 3:15 p.m., licensed practical nurse (LPN)A stated residents with CHF should be monitored closely for weight increases as this could be a sign of fluid overload. LPN-A stated this would be completed by the certified nursing assistants (CNA) with morning cares. LPN-A went on to say she did not routinely follow up with CNAs to confirm scheduled weights were completed. During interview on 12/20/2024 at 4:11 p.m., director of nursing (DON) confirmed R43 had an order for weights three times weekly on Monday, Wednesday, and Friday and was missing documentation for more than half of scheduled weights over the past 5 months. DON stated when a physician orders scheduled weights, she expects nursing staff to follow the order, obtain the weight and if it is not completed staff should document the reason why and communicate any missed weights to the provider. DON stated this process was important for monitoring for signs/symptoms of heart failure and the purpose of the scheduled weights was to avoid an acute episode of heart failure. A policy was requested. However, not provided. 49654

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 49657 Based on record review and interviews the facility failed to ensure the required staffing information was posted daily. This had the potential to affect all 57 residents residing in the facility and their visitors who may wish to view the information. Findings include: On 12/16/24 upon entrance the staff posting was observed to include liscensed staff and total hours worked. On 12/17/24 the staff posting included liscensed staff and total hours worked. Staff postings dated 11/17/24 through 12/20/24, lacked evidence of accurate postinging information as evidenced by lack of information regarding how many liscensed staff were working in the facility each day, how many hours worked, and the total hours of all liscensed staff working on the days listed above. On 12/20/24 at 2:01 p.m., the director of nursing stated the information on the staff postings was incorrect and there had been miscommunication. The information had been lost. On 12/20/24 at 2:08 p.m., the director of nursing and the HR manager (O)-F stated they would run a report through their charting system and then post the posting for Monday through Friday daily and would pre-post it for the weekend. Both the DON and O-F confirmed the information on the daily staffing sheets was incorrect and/or not there. It was not updated in person on the weekends, and they had not kept the information for the time frame requested. On 12/20/24 at 2:28 p.m., the DON stated their expectation was the staff posting to be updated and posted with correct information and was important to know how many licensed staff and residents are in the building, however did not indicate daily posting as required. The facility policy was requested and none was provided.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 49657 Based on interview and record review the facility failed to conduct and document a comprehensive facility-wide assessment which included all of the necessary components to provide adequate care and services to the residents in the facility. The deficient practice had the potential to affect all 57 residents in the facility. Findings include: During the entrance conference on 12/16/24 at 9:19 a.m., the team leader requested the facility assessment to be provided within four hours of entrance. Subsequent requests were made on 12/19/24 and 12/20/24. On 12/20/24 at 6:11 p.m., the administrator sent an email to the survey team containing the document titled Facility Assessment Tool 12-2024. Review of the entire document with an assessment date of 9/5/2024, indicated the assessment lacked important components to ensure the facility identified all the resources necessary to care for and provide services to their residents. The provided document had some sections filled out and others left blank. The missing components included but were not limited to: 1) The facility's information such as name of the facility, names of current leadership and management, medical director. 2) The quality assurance teams input or participation in the facility assessment formation or update. 3) List of personal or person from whom the information was gathered, or if resident or family member input was taken into account when the assessment was created. 4) A contingency staffing plan. 5) Staff Competencies and skill sets. 6) Health information technology resources. On 12/20/24 at 5:54 p.m., the administrator confirmed they were responsible for writing and creating the facility assessment. Their expectation was its completion should have been verified while they worked on their emergency preparedness program. It was important to complete a facility assessment to help guide staffing needs, equipment, and resident care needs. A facility assessment Policy was request and none was provided.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49654 Based on interview and document review the facility failed to maintain a Quality Assurance Assessment/ Quality Assurance and Performance Improvement (QAA/QAPI) program that was effective in identifying, assessing, performing, developing and implementing appropriate plans of action to assure clinical care, quality of care, resident rights and services were identified to maintain acceptable levels of performance. Furthermore, the facility failed to conduct ongoing quality assessment and assurance activities, develop, and implement appropriate plans of action to correct repeated quality deficiencies identified during the survey the facility was aware of or should have been aware of which had the potential to adversely affect all 57 residents which resided in the facility. Findings include: See F552: The facility failed to ensure changes in medication were communicated to residents (R33) and or resident representative infringing on the resident's right to be informed. See F625: The facility failed to provide a written notice of a bed-hold at the time of transfer for hospitalization s as required. See F684: The facility failed to monitor and implement interventions for heart failure. This resulted in actual harm to R33 who was re-hospitalized on exacerbation of heart failure. See F838: The facility failed to conduct and document a comprehensive facility-wide assessment which included all of the necessary components to provide adequate care and services to the residents in the facility. See F880: The facility failed to ensure appropriate hand hygiene during medication pass and while handling soiled clothing to reduce the risk of infection. The facility's QAPI meeting minutes for the past 12 months were requested, however the facility only provided Quality Assurance and Assessment (QAA)/Quality Assessment and Performance Improvement meeting agenda dated October 17th, 2024. The meeting agenda did not identify previous recertification survey results. The meeting agenda identified the current performance improvement project (PIP) as meds not available on electronic medication administration record (EMAR). During interview on 12/20/24 at 4:11 p.m., the director of nursing (DON) stated she was aware of ongoing issues of quality of care and specifically concerns of staff obtaining and documenting resident weights. DON stated she had identified the issue in October 2024, however failed to provide staff education or training until two months later on 12/20/24. During interview on 12/20/24 at 5:42 p.m. the administrator stated the facility held monthly QAA meetings and quarterly QAPI meetings, however no monthly QAA meeting minutes were provided, and only one QAPI meeting agenda dated 10/17/24 was provided. The administrator stated the facilities current PIP included weights, skin audits, staffing and medication administration, however the provided QAPI agenda lacked evidence of the reported PIP projects. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Undated facility policy titled Quality Assurance and Performance Improvement (QAPI) Program identified the objections of the QAPI program as: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. 3. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. 4. Establish systems through which to monitor and evaluate corrective actions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40944 Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene for 2 of 4 staff observed for medication pass. Further, the facility failed to ensure 1 of 1 staff consistently followed infection control standards of practice for handling soiled clothing to reduce the risk of infection. This practice had the potential to affect all 57 residents, staff, and visitors. Findings include: During observation on 12/19/24 at 7:51 a.m., registered nurse (RN)-C was preparing and administering medications for a resident. RN-C prepared medication in medication cup, locked the medication cart, went to resident in common area and handed medication cup to the resident who took medications independently. RN-C returned to the cart, picked up a new medication cup off of a stack of medication cups, pulled up information for a new resident on computer and unlocked medication cart to retrieve medications. RN-C did not wash hands with soap and water or utilize alcohol-based hand sanitizer during this process. During interview on 12/19/24 at 7:54 a.m., RN-C stated she always utilized alcohol-based hand sanitizer when passing medications. She stated she was going to throw away the medication cups and utilize alcohol-based hand sanitizer before preparing the next resident's medications. During observation on 12/19/24 at 11:49 a.m., licensed practical nurse (LPN)-A completed a blood sugar check utilizing a glucometer stored in the resident's room. LPN-A utilized alcohol-based hand sanitizer, applied gloves, cleansed resident's finger, and completed blood sugar check appropriately. LPN-A disposed of supplies and removed gloves. LPN-A did not wash hands with soap and water or utilize alcohol-based hand sanitizer after removing gloves. LPN-A then drew up insulin, applied gloves, cleansed administration site, and gave insulin correctly. LPN-A disposed of supplies and removed gloves. LPN-A did not wash hands with soap and water or utilize alcohol-based hand sanitizer after removing gloves. LPN-A then picked up a new medication up and pulled up information to administer medication to a different resident without washing hands. During interview on 12/19/24 at 11:50 a.m., LPN-A stated she should have utilized alcohol-based hand sanitizer between residents and after completing tasks, but she forgot. During interview on 12/20/24 at 11:32 a.m., director of nursing (DON) stated she expected staff to utilize alcohol-based hand sanitizer between each resident and before and after tasks while passing medications. She stated this was important to reduce infection. Facility policy titled Medication Administration dated April 2019, included staff will follow established infection control procedures, including handwashing, for medication administration. On 12/19/24 at 8:06 a.m., nursing assistant (NA)-A was observed holding a pair of dark blue, plaid, flannel pants as she walked down the 2nd floor hallway, past the nurse station, and into the tub room. However, NA-A was observed to to be wearing gloves and the clothing was not secured in a bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 8:07 a.m., NA-A confirmed the soiled clothing should have been placed in a bag before the item was removed from the resident's room and brought to the tub room. NA-A did not confirm nor deny wearing gloves. On 12/20/24 at 1:25 p.m., infection preventionist (IP) stated staff were expected to have soiled items bagged and gloves on when handling soiled clothing/linens. IP stated soiled items needed to be contained, and gloves worn as a protective barrier, to prevent the spread of infection. Policy requested, but not provided by facility. 44645 49035

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and record review, the facility failed to provide pneumococcal vaccine in a timely manner to 1 of 5 residents (R45) reviewed for immunizations. Findings include: R45's admission Minimum Data Set (MDS) dated [DATE], included an admitted [DATE]. R45's MDS indicated he was not up to date with the Pneumococcal vaccinations. Undated facility document titled Pneumococcal Vaccination Consent/Declination was marked yes next to the question asking if R45 would have been interested in receiving the recommended pneumococcal vaccination. Form was signed by R45 and uploaded to the electronic medical record (EMR) within the same week as admission. During an interview on 12/20/24 at 11:39 a.m., director of nursing (DON) stated she was unsure of the process of reviewing for and giving immunizations and would have to defer to the infection preventionist. During an interview on 12/20/24 at 1:20 p.m., infection preventionist (IP) stated she reviewed immunization status when a resident was admitted utilizing the Minnesota Immunization Information Connection (MIIC). The IP utilized an app on her phone recommended by the facility pharmacy to find out which pneumococcal vaccinations a resident was eligible for and had residents sign a consent to show if they were interested in receiving an immunization or not. The immunization would be ordered from the pharmacy after review and consent. IP stated she would follow up with the pharmacy if she had not received the immunization within a few days. IP confirmed the immunization should have been received and given by 12/20/24. Facility policy on pneumococcal vaccination requested and not received.