STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOTHER OF MERCY SENIOR LIVING	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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were free from verbal abuse for 1 of 3 resident (R1) reviewed for abuse. Findings include: A review of the facility Incident Report number 1 submitted on 6/26/20, at 8:57 p.m. indicated on 5/22/20, at 5:30 p.m. R1 was sitting at a table in the dining area when NA-A and NA-B were talking with R1 and telling her to shake your hooters, shake your hooters. NA-A and NA-B continued to repeat shake your hooters to R1 a few times each, then NA-B told R1 here I will show you. The witness left the area and did not witness anything further. Review of the incident report number 0 to the SA dated 6/26/20, at 8:36 p.m. indicated on 6/19/20, at 7:30 p.m. nursing assistant (NA)-C approached R1 sitting at a table and leaned on this table near R1 and told R1 to stop looking at my boobs. You've got big boobs of your own. R1 replied I do? NA-C walked away from the area. R1's face sheet undated, indicated R1's [DIAGNOSES REDACTED]. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1 was cognitively impaired and that R1 needed the assistance of one staff with activities of daily living (ADL's). R1's care plan revised 3/20/20, indicated R1 had difficulty making self-understood as well as fully understanding what is said to her related to Alzheimer's. The care plan indicated R1 was receptive to redirection from staff. R1's decision making ability was poor and required supervision for safety. During an interview on 6/29/20, at 1:30 p.m. the housekeeper (HSK) -A stated the incident occurred on 5/14/20, at approximately 5:30 p.m. in the dining area during the meal time. (the report indicated the first incident occurred on 5/22/20) HSK-A stated she witnessed NA-A and NA-B sitting next to R1 and directed R1 to shake her hooters. NA-A and NA-B both said this two times to R1. NA-B stated to R1, I will show you, don't you know what hooters are? Then both NA-A and NA-B chuckled. On 5/15/20, HSK-A reported to human resources manager (HRM) that the incident occurred and HRM stated she would take care of this and that the administrator would be informed of the incident. HSK-A stated in the middle of the next week she called the administrator and told him what she had witnessed. The administrator stated the video would be viewed. HSK-A indicated she also told licensed practical nurse (LPN)-A on 5/15/20, about the incident with R1. HSK-A further stated the next incident with R1 was witnessed on 6/19/20, about 7:30 p.m. when HSK-A was cleaning the dining room. HSK-A stated she witnessed NA-C leaning over talking to R1 with NA-C having her left arm over R1's shoulder and NA-C said stop looking at my boobs. NA-C stated to R1, you have boobs too, and R1 stated I do? Then NA-C left the dining area. HSK-A stated she told LPN-A about the incident. HSK-A further stated she called the administrator and left a message, however, the administrator never called HSK-A back. HSK-A stated she should have let other nursing staff know what she witnessed. During an interview on 6/29/20, at 12:14 p.m. with the director of nursing (DON) stated nursing assistant (NA)-C was talked to about the incident on 6/27/20, and agreed it was inappropriate to talk to R1 about big boobs. During an interview on 6/29/20, at 4:37 p.m. NA-B stated she did not recall the alleged incident. NA-B stated she would not have said those words to R1. NA-B stated those words shake your hooters would be inappropriate to say to any resident. During an interview on 6/30/20, at 12:11 p.m. when asked about the alleged incident NA-C denied saying anything about big boobs. NA-C stated once in a while R1 says things about my boobs or butt and we laugh. During interview and a review of video of the second incident on 6/30/20, at 1:17 p.m. with ADON revealed that on 6/19/20, at 7:55 p.m. NA-C went to the table where R1 was sitting. NA-C leaned over table facing R1 and put left arm on R1's left shoulder and looks at R1. ADON stated NA-C admitted to the DON that she said stop looking at my boobs to R1. ADON said if I would have known about the first incident with R1, the second incident might have not happened. A telephone message was left on 6/30/20, at 12:24 p.m. and on 7/1/20, at 12:38 p.m. NA-A did not respond to phone calls from surveyor. A review of an Employee Coaching Form dated 6/29/20, indicated NA-B was certain she did not say those words but may have been there and laughed but did not clearly remember. The form revealed failure to improve would result in further disciplinary action. A review of an Employee Coaching Form dated 6/28/20, indicated R1 with a [DIAGNOSES REDACTED]. The form revealed any further inappropriate comments to any resident would result in further disciplinary action. A review of an Employee Coaching Form dated 6/28/20, indicated on 6/27/20, it was reported that NA-A was telling R1 to shake your hooters. NA-A admitted that this had occurred and agreed it was not appropriate. The form revealed if behavior was repeated, further disciplinary action would be taken. During an interview on 6/29/20, at 3:02 p.m. the administrator stated he could not recall dates and times, of the reported incidents and that he did not write the dates down maybe about four to four and half weeks ago was his best guess. The administrator stated HSK-A was working on the first floor and reported that staff were shaking their shoulders and putting their chest out and moving their shoulders to shake their boobs with R1. The administrator further stated he did not view the video of the incident. However the HRM did, and there was nothing definitive on the video with staff or R1 shaking breasts. The administrator stated HRM was unsure if she looked at the right date of the video. The administrator also stated he followed up with HSK-A three days later but had not gotten to the investigation yet. The administrator further stated he was contacted by the DON regarding another incident with R1 on 6/29/20, and to his knowledge the investigation had started. The administrator stated he did not consider this an allegation of abuse. During an interview on 7/1/20, at 12:47 p.m. licensed practical nurse (LPN)-A stated she was told of the first incident by the housekeeper on 5/14/20 and that she told HSK-A to report to human resources and the administrator what was witnessed with R1, NA-A and NA-B. LPN-A further stated the housekeeper told her of another incident on 6/19/20, with R1 and NA-|C. LPN-A stated she reported both incidents to the ADON. During an interview on 6/29/20, the ADON stated she became aware of the alleged abuse on 6/26/20, and filed two reports to the SA, let the director of nursing (DON) and administrator know of the alleged abuse and started the investigation. ADON stated the incident was abuse and needed to be reported and investigated when it initially occurred. The ADON stated there was a lack of reporting to nursing and no investigation was completed. During an interview on 6/29/20, at 12:14 p.m. the DON stated the policy indicated all health care workers are mandated reporters so yes the housekeeper should have reported the incident to the nurse, charge nurse, or the nurse on call immediately. The DON stated HSK-A did report but well after the fact. The facility policy Abuse Prevention and Vulnerable Adult Procedure dated 10/18/19, included the following definitions: -Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also include the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being. -Verbal abuse: as the use of oral, written or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The facility policy Abuse Prevention and Vulnerable Adult Procedure dated 10/18/19, indicated all residents residing in the facility will be protected from maltreatment. The facility requires all suspected maltreatment be reported promptly. The Professional or Professional's delegate, while engaged in the care of vulnerable adults will make sure that a repot is made out, that the internal investigation begins immediately, the appropriate

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) reporting takes place an interventions are implemented to provide the vulnerable adult with a safe living environment. When in doubt be sure to report. The administrator is notified immediately.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to immediately report incidents of allegations of verbal abuse to the State Agency (SA) within two hours, as required, for 1 of 3 residents (R1) reviewed for abuse reporting. Findings include: Review of the incident report number 0 to the SA dated 6/26/20, at 8:36 p.m. indicated on 6/19/20, at 7:30 p.m. nursing assistant (NA)-C approached R1 sitting at a table and leaned on this table near R1 and told R1 to stop looking at my boobs. You've got big boobs of your own. R1 replied I do? NA-C walked away from the area. Review of the incident report number 1 to the SA dated 6/26/20, at 8:57 p.m. indicated NA-A and NA-B on 5/22/20, at 5:30 p.m. were talking with R1 and telling R1 shake your hooters, shake your hooters. NA-A and NA-B stated this a few times each then NA-B told R1 here, I'll show you. The initial reporter left the general area at that time and did not witness what occurred after that statement. R1's face sheet undated indicated R1's [DIAGNOSES REDACTED]. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1 was cognitively impaired. R1 needed the assistance of one staff with activities of daily living (ADL's). During an interview on 6/29/20, at 1:30 p.m. the housekeeper (HSK) -A stated the incident occurred on 5/14/20, at approximately 5:30 p.m. in the dining area during the meal time. (the report indicated the first incident occurred on 5/22/20) HSK-A stated she witnessed NA-A and NA-B sitting next to R1 and directed R1 to shake her hooters. NA-A and NA-B both said this two times to R1. NA-B stated to R1, I will show you, don't you know what hooters are? Then both NA-A and NA-B chuckled. On 5/15/20, HSK-A reported to human resources manager (HRM) that the incident occurred and HRM stated she would take care of this and that the administrator would be informed of the incident. HSK-A stated in the middle of the next week she called the administrator and told him what she had witnessed. The administrator stated the video would be viewed. HSK-A indicated she also told licensed practical nurse (LPN)-A on 5/15/20, about the incident with R1. HSK-A further stated the next incident with R1 was witnessed on 6/19/20, about 7:30 p.m. when HSK-A was cleaning the dining room. HSK-A stated she witnessed NA-C leaning over talking to R1 with NA-C having her left arm over R1's shoulder and NA-C said stop looking at my boobs. NA-C stated to R1, you have boobs too, and R1 stated I do? Then NA-C left the dining area. HSK-A stated she told LPN-A about the incident. HSK-A further stated she called the administrator and left a message, however, the administrator never called HSK-A back. HSK-A stated she should have let other nursing staff know what she witnessed. During an interview on 6/29/20, at 11:27 a.m. the assistant director of Nursing (ADON) stated she became aware of the alleged abuse on 6/26/20, and filed two reports to the SA, let the DON and administrator know of the alleged abuse. The ADON stated there was lack of reporting to nursing when the incidents occurred and no investigation was initially completed. During an interview on 6/29/20, at 12:14 p.m. the director of nursing (DON) stated once she was aware of the incidents, the NA's involved in the incidents were talked to prior to their next shift and were told this was not appropriate and would not be tolerated. The DON stated the policy indicated all health care workers are mandated reporters, therefore HSK-A should have reported the incident to the nurse, charge nurse, or the nurse on call, immediately. The DON stated the HSK-A did report but well after the fact. During an interview on 6/29/20, at 2:16 p.m. HRM stated she was called about a month ago regarding an incident with R1. HRM stated the video was observed and there was no audio with the video. HRM said you could not tell what was being said, R1 was sitting at the table NA-A was standing across from R1 and NA-B was sitting next to R1. HRM stated there were no gestures by staff or R1. HRM said the video goes away after 21 days and there was not a copy saved. The HRM stated she told the administrator what was seen on the video the day she watched the video. HRM said there was no documentation from her about when the video was watch, what day of the video was watched, or when HSK-A had contacted her. During an interview on 6/29/20, at 3:02 p.m. the administrator stated he was not be able to recall dates and times this was reported, and that he did not write them down. The administrator stated HRM said there was nothing definitive on the video with staff or R1 shaking breasts. The administrator stated HRM was unsure if she looked at the right date of the video. The administrator stated he followed up with HSK-A three days later. During an interview on 7/1/20, at 12:47 p.m. LPN-A stated was told of the first incident by the housekeeper on 5/14/20. LPN-A stated she told HSK-A to report to human resources and the administrator what was witnessed with R1 and NA-A and NA-B. LPN-A stated HSK-A then told her of another incident on 6/19/20, with R1 and NA-C. LPN-A stated she reported both incidents to the ADON on 6/26/20. LPN-A stated it bothered me that no one was doing anything about R1 so I reported to the ADON. During an interview on 7/1/20, at 1:04 the ADON stated this allegation was abuse and should have been reported immediately when it occurred. The facility policy Abuse Prevention and Vulnerable Adult Procedure dated 10/18/19, indicated all residents residing in the facility will be protected from maltreatment. The facility requires all suspected maltreatment be reported promptly. The Professional or Professional's delegate, while engaged in the care of vulnerable adults will make sure that a repot is made out, that the internal investigation begins immediately, the appropriate reporting takes place an interventions are implemented to provide the vulnerable adult with a safe living environment. When in doubt be sure to report. The administrator is notified immediately. The policy gave the definition of verbal abuse as the use of oral, written or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The reporting portion of the policy indicated the facility would report all alleged violations and substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation. In addition, any allegations(s) of abuse and/or neglect will be reported to the AS immediately but no later than two(2) hours whether the abuse and/or neglect is substantiated or not.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to investigate an incidents of potential verbal abuse to the State Agency (SA), for 1 of 3 residents (R1) reviewed for abuse reporting. Findings include: Review of the incident report number 1 to the SA dated 6/26/20, at 8:57 p.m. indicated NA-A and NA-B on 5/22/20, at 5:30 p.m. were talking with R1 and telling R1 shake your hooters, shake your hooters. NA-A and NA-B stated this a few times each then NA-B told R1 here, I'll show you. The initial reporter left the general area at that time and did not witness what occurred after that statement. R1's face sheet undated indicated R1's [DIAGNOSES REDACTED]. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1 was cognitively impaired. R1 needed the assistance of one staff with activities of daily living (ADL's). During an interview on 6/29/20, at 1:30 p.m. the housekeeper (HSK) -A stated the incident occurred on 5/14/20, at approximately 5:30 p.m. in the dining area during the meal time. (the report indicated the first incident occurred on 5/22/20) HSK-A stated she witnessed NA-A and NA-B sitting next to R1 and directed R1 to shake her hooters. NA-A and NA-B both said this two times to R1. NA-B stated to R1, I will show you, don't you know what hooters are? Then both NA-A and NA-B chuckled. On 5/15/20, HSK-A reported to human resources manager (HRM) that the incident occurred and HRM stated she would take care of this and that the administrator would be informed of the incident. HSK-A stated in the middle of the next week she called the administrator and told him what she had witnessed. The administrator stated the video would be viewed. HSK-A indicated she also told licensed practical nurse (LPN)-A on 5/15/20, about the incident with R1. During an interview on 6/29/20, at 11:27 a.m. the assistant director of Nursing (ADON) stated she became aware of the alleged abuse on 6/26/20, and filed the report with the SA, let the DON and administrator know of the alleged abuse. The ADON stated there was lack of reporting to nursing and no investigation was initially completed. During an interview on 6/29/20, at 12:14 p.m. the director of nursing (DON) stated once they were aware of the incident, the NA's involved in the incidents were talked to prior to their next shift and were told this was not appropriate and would not be tolerated. During an interview on 6/29/20, at 2:16 p.m. HRM stated she was called about a month ago regarding an incident with R1. HRM stated the video was observed and there was no audio with the video. HRM said you could not tell what was being said, R1 was sitting at the table NA-A was standing across from R1 and NA-B was sitting next to R1. HRM stated there were no gestures by staff or R1. HRM said the video goes away after 21 days and there was not a copy saved. The HRM stated she told the administrator what was seen on the video the day she watched the video. HRM said there was no documentation from her about when the video was watch, what day of the video was watched, or when HSK-A had contacted her. During an interview on 6/29/20, at 3:02 p.m. the administrator stated he was not be able to recall dates and times this was reported, and that he did not write them down. The administrator stated HRM

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) said there was nothing definitive on the video with staff or R1 shaking breasts. The administrator stated HRM was unsure if she looked at the right date of the video. The administrator stated he followed up with HSK-A three days later. During an interview on 7/1/20, at 12:47 p.m. LPN-A stated was told of the incident by the housekeeper on 5/14/20. LPN-A stated she told HSK-A to report to human resources and the administrator what was witnessed with R1 and NA-A and NA-B. LPN-A stated she reported the incident to the ADON on 6/26/20. LPN-A stated it bothered her that no one was doing anything about R1 so she reported to the ADON. The facility policy Abuse Prevention and Vulnerable Adult Procedure dated 10/18/19, indicated all residents residing in the facility will be protected from maltreatment. The facility requires all suspected maltreatment be reported promptly. The Professional or Professional's delegate, while engaged in the care of vulnerable adults will make sure that a repot is made out, that the internal investigation begins immediately, the appropriate reporting takes place an interventions are implemented to provide the vulnerable adult with a safe living environment. When in doubt be sure to report. The administrator is notified immediately. The policy gave the definition of verbal abuse as the use of oral, written or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The reporting portion of the policy indicated the facility would report all alleged violations and substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation.