



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

May 20, 2026

Administrator
ST CLARE LIVING COMMUNITY OF MORA
110 NORTH 7TH STREET
MORA, MN 55051

RE: CCN: 064628000

Cycle Start Date: May 1, 2026

Dear Administrator:

On May 1, 2026, survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 1, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 4, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 4, 2026, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)).

They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, ST CLARE LIVING COMMUNITY OF MORA is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 1, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the

Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 1, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days

after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502.

Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

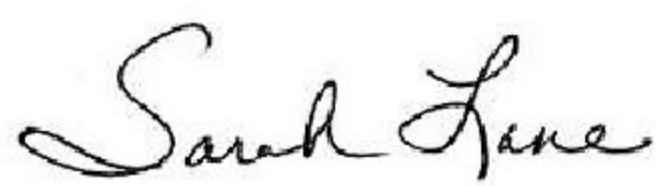
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/27/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on April 27, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Clare Living Community of Mora, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us			K0000			05/28/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/27/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: St. Clare Living Community of Mora is a 1-story building with small partial basement. The original building was constructed in 1969 and additions constructed in 1999. The 1969 building is of type II(111) construction and the 1999 building is type V(111) construction. To the north a single story type V(111) assisted living facility also adjoins and is separated by 2 hour construction with a 90 minute rated, self closing door. Another addition of Type V(111) construction opened to the west in 2005. The facility has a capacity of 65 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			05/28/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by:			K0345	It is the policy of St. Clare Living Community of Mora to provide a safe environment for all residents and staff. St. Clare Living Community failed to conduct the semi-annual fire alarm testing and documentation. On 5/28/26 Summit Fire Protection Company completed facility semi-annual fire alarm testing inspection with no concerns in the system. Summit Fire Protection has added facility to system for semi-annual inspection. The Environmental Service Director will continue to ensure semi-annual alarm testing and documentation is completed per fire safety codes. The Environmental Director or designee is responsible for compliance.		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/27/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0345 SS = F Bldg. 01	Continued from page 2 Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/27/2026 at 2:00 PM, it was revealed by a review of available documentation that the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Enviromental Service Director and a Maintenance Associate verified this deficient finding at the time of discovery.			K0345			06/09/2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)			K0321	It is the policy of St. Clare Living Community of Mora to maintain hazardous storage room doors. On 5/20/26 Mattson electric was in facility to evaluate the door closer function. Mattson ordered magnetic door hold to be installed to ensure door would automatically release/close upon activation of alarm system. Magnetic door hold was installed on 5/27/26. All magnetic door holds are tested monthly during facility fire drills. The Environmental Service Director or designee is responsible for compliance.		05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/27/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0321 SS = D Bldg. 01	Continued from page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 04/27/2026 at 3:55 PM, it was revealed by observation the employee entrance (120D) is being used as a combustible storage room and did not have a door closer on the door. An interview with the Environmental Services Director and a Maintenance Associated verified this deficient finding at the time of discovery.			K0321			05/27/2026
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet			K0923	It is the policy of St. Clare Living Community of Mora maintain proper medical gas storage. On 5/14/26 all combustible materials were placed in a UL listed metal cabinet. The Environmental Service Director will check oxygen room for proper storage of combustibles as part of facility operation rounds. The Environmental Service Director or designee is responsible for compliance.		05/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/27/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0923 SS = D Bldg. 01	Continued from page 4 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 04/27/2026 at 3:14PM, it was revealed by observation that the Med Gas (O2) Storage Room contained storage of combustible materials. An interview with the Environmental Services Director and a Maintenance Assistant verified this deficient finding at the time of discovery.			K0923			05/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000	Initial Comments On 4/27/26-5/1/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.			E0000			05/26/2026
F0000	INITIAL COMMENTS On 4/27/26-5/1/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to ensure the code alert system (a wander management system to protect residents from elopement) was functioning properly, failed to follow manufacture recommendation for weekly testing, and failed to follow manufacture recommendations for inspection. This resulted in an immediate Jeopardy situation for two residents (R19, R12) who were at risk for elopement and were able to get through the main doors, due to failure of the doors to lock as required per the code alert system. In addition, the facility failed to adequately assess and develop care plans for residents identified at risk for elopement and wandering for 14 of 14 residents (R19, R12, R3, R4, R13, R17, R18, R22, R25, R28, R32, R34, R37, R46) who were assigned code alert devices and had the potential for elopement. The IJ began on 4/30/26 at 2:18 p.m., when R12 was able to exit the building due to code alert system malfunction. The administrator and director of nursing (DON) were notified of the IJ on 4/30/26, at 7:35 p.m. The immediate jeopardy was removed			F0000			

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	Continued from page 1 on 5/1/26 at 4:36 p.m., however, non-compliance remained at a lower scope and severity, level 2, isolated scope, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted on 5/1/26. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			05/26/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure the code alert system (a wander management system to protect residents from elopement) was functioning properly, failed to follow manufacture recommendation for weekly testing, and failed to follow manufacture recommendations for inspection. This resulted in an immediate Jeopardy situation for two residents (R19, R12) who were at risk for elopement and were able to get through the main doors, due to failure of the doors to lock as required per the code alert system. In addition, the facility failed to adequately assess and develop care plans for residents identified at risk for elopement and wandering for 14 of 14 residents (R19, R12, R3, R4, R13, R17, R18, R22, R25,			F0689	It is a policy of St. Clare Living Community that residents are free of harm, or the potential to be harmed while at the facility. It is an expectation that residents will be safe and consistently monitored to ensure they do not leave the facility unknowingly. The goal at this time is to ensure no further elopements can or will occur. Continuous supervision will be conducted for R12, R19, and all like residents. Care plans for residents at high risk for elopement will also be reassessed and updated as determined through assessment. Documentation that high-risk residents have been re-evaluated and that their updated care plans include specific, non-restrictive, and individualized safety interventions. Quarterly care plans for residents with elopement risk will be ongoing to ensure accuracy. All code alerts will be immediately tested to verify all alarms function as expected according to manufacturer guidelines. This information will be documented in a log and will be audited three times per week for four weeks, followed by one time per week thereafter. Daily logs will be signed by the maintenance director or designee showing that all door sensors, keypads, and master alarm panels were tested and passed. Resident families and his or her physician will be notified of the incident and the immediate protective measures that have been taken. The elopement policy will be reviewed/updated and distributed to staff for notification of the policy prior to their next scheduled shift. Staff will be required to provide a signature acknowledging that they have read and understood the policy. A rapid		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 2 R28, R32, R34, R37, R46) who were assigned code alert devices and had the potential for elopement. The IJ began on 4/30/26 at 2:18 p.m., when R12 was able to exit the building due to code alert system malfunction. The administrator and director of nursing (DON) were notified of the IJ on 4/30/26, at 7:35 p.m. The immediate jeopardy was removed on 5/1/26 at 4:36 p.m., however, non-compliance remained at a lower scope and severity, level 2, isolated scope, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings Include: The manufacturer Code Alert System book in the facility binder recommended: -Weekly testing of the code alert units and instructed replacement of expired devices and/or devices that failed testing. -Testing of each detection zone (doors) on a regular basis, ideally weekly. -Quarterly service inspections by vendor. Logs titled Code Alert Alarm Testing dated between 1/2025, and 4/2025, showed the North internal door/offices, Main Entry/Exit Long Term, South Exit, East Exit, West Connector Exit, and the West View Entry/Exit had been tested monthly. Logs titled Wander Guard Monitor sheets dated between 1/2026, and 5/1/26, listed all residents with a code alert monitor, the monitor location, and the device expiration date. Device checks were documented as completed weekly. The most recent log dated 4/2026, listed 14 residents with code alert devices: R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46. R19 was admitted to the facility on 5/8/2017. R19' significant change MDS assessment dated 2/16/26, indicated R19 was severely cognitively impaired with the diagnosis of Alzheimer's disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R19 had not exhibited wandering. R19's care plan reviewed 2/10/26, lacked interventions for elopement and wandering. R19's most recent elopement assessment was completed on 2/9/26. The assessment identified R19 as low risk for elopement and interventions included clothing labeled with identification, identification			F0689	Continued from page 2 response procedure will be developed in the policy for code alert system malfunctions, including immediate notification to maintenance, nursing, and administration. Quarterly QAPI meetings will also track audit reports, any incident that has occurred, and any corrective action taken. Mandatory education/training will be assigned for all staff to ensure competency relating to elopement prevention protocols and code alert system testing policies and procedures through Healthcare Academy, the facility educational software system, live all staff in-services, policy review/updates in written form. The code alert system will be serviced and inspected immediately by the code alert vendor to ensure it is performing as expected and every quarter thereafter to ensure optimal performance.		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 3 band on resident. The Door Alarm band applied (code alert device) was not selected. R19's progress note did not include an entry regarding R19's attempt to leave the building on 4/29/26. During an observation on 4/29/26 at 10:07 a.m., R19 wheeled their wheelchair to the main entrance of the facility. R19 proceeded to wheel self through the first door into the entrance vestibule. The alarm went off, but the door did not lock. NA-J responded and was able to redirect R19 out of the entry and back to the central tv area. R19 was heard telling NA-J "I was just thinking about a change of scenery. Oh, sure let's go to the tv area." R19's code alert device was attached above the left wheel of their wheelchair. During an interview on 4/30/26 at 10:48 a.m., nursing assistant NA-J stated yesterday they had heard the alarm go off and had responded to the main entry. R19 had been partially through the first door when they reached R19. Usually, the door would lock when a resident got withing 3 feet or so, but it had not locked yesterday. R12 was admitted to the facility on 10/9/23. R12's quarterly MDS assessment dated 4/29/26, indicated R12 was severely cognitively impaired with diagnoses of non-Alzheimer's dementia and anxiety. MDS Section P. indicated a wander guard alarm was not in use. Section E900 indicated R12 had not exhibited wandering. R12's care plan last reviewed 4/16/26, lacked interventions for elopement and wandering. R12 had documented elopement assessments completed by the licensed social worker (LSW-A) on 10/27/23, 9/15/24, 8/18/25. R12's most recent assessment completed on 8/18/25, indicated R12 was a low risk for elopement and interventions in place included: clothing labeled, and an identification band placed on the wrist. The door alarm band applied (code alert device) was not selected as an intervention. During an observation on 4/28/26 at 8:40 a.m., R12 set off code-alert alarm attempting to ambulate out the main facility door. R12 went through the inside door into the vestibule where her walker got hung up on the rug pushing it upwards along the legs of the walker. Staff responded and redirected R12 back inside and away from the entrance door. During an observation on 4/30/26 at 2:18 p.m., R12			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 4 walked out of their room with their wheeled walker directly to the main entrance. R12 paused at the main entrance door, stated “I think my car is out there” and then proceeded through the first door. R12’s walker initially got caught up on the rug, but R12 was able to push walker beyond the rug and proceeded outside. Staffing coordinator (SC)-D saw R12 exiting the building and followed R12 out asking that surveyors 1 or 2 get their cell phone and bring it to them. Surveyor 2 notified the DON who was passing down the hallway a resident had made it outside of the building and SC-D had followed and needed their phone. The DON brought the phone out to SC-D and left the area. SC-D and R12 sat on a bench along the driveway. At 2:20 p.m., SC-D and R12 came back inside the facility. R12 returned to their room which was near the main entrance door During an observation on 5/1/26 at 9:07 a.m., R12 walked out of their room to the main entrance door. R12 made it through the first door and into the vestibule before SC-D redirected R12 back inside and away from the door. The alarm went off once R12 went through the first door. SC-D stated they were keeping a staff at the door 24/7 until the door was fixed. Progress notes entered by LSW-A on 10/30/25, 1/22/26, and 4/16/26, indicated R12’s elopement assessments had been reviewed with no change. R12’s EMR lacked documentation regarding R12’s successful exit of the building on 4/30/26, or their attempts to exit the building made on 4/28/26, and 5/1/26. On 4/30/26 at 2:20 p.m., the maintenance department responded to a call regarding the door. The director of plant services (DPS)-A stated the door should have locked when R12 got near it, and once R12 made it through the door the door should have alarmed. During an interview on 4/30/26 at 2:23 p.m., SC-D stated they had seen R12 heading to the door, initially they thought it had locked, but then R12 went through the door, and it didn't alarm so they followed R12 outside. R12 agreed to come back in for coffee so they had brought R12 coffee when they came back in. On 4/30/26 at 2:30 p.m., DPS-A and maintenance associate (MA-B) started adjusting and testing the main entrance door code alert system. The door continued to fail with testing and readjusting. During an interview on 4/30/26 at 2:56 p.m., SC-D			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 5 stated R12 had a history of trying to get out of the facility. Usually when R12 tried to leave, R12 was looking for their car, house, or family. Lately R12 had been attempting to leave more frequently. During an interview on 4/30/26 at 3:08 p.m., occupational therapist (OT)-C stated R12 was able to walk from her room to the dining room and back again. During an interview on 4/30/26 at 3:51 p.m., NA-A stated she was familiar with R12 and said she was able to walk around the facility using her walker. NA-A stated R12 could walk to activities using her walker. NA-A stated R12 would try to leave the facility “a lot”, mostly in the evenings. NA-A stated she would want to go pick up her kids, when this occurred, they would call her son, and he would come over. NA-A stated she was not aware of her ever leaving the building. During an interview on 4/30/26 at 3:55 p.m., NA-C stated R12 could walk on her own using her walker, stated she was a “good walker”. NA-C stated R12 would try to leave the building “mostly in the evening”. NA-C stated she had seen R12 leave the building about a month previously, stated she got between the inner and outside door, the alarm sounded. During an interview on 4/30/26 at 4:01 p.m., NA-D stated R12 walked independently using a walker. NA-D stated she would try to leave the building and stated the evening before she was crying, trying to find her baby and asking how to get out of the building. She was not successful. During an interview on 4/30/26 at 4:05 p.m., NA-E stated R12 walked independently using a walker. NA-E was not aware of her trying to leave the building but stated last summer she was wanting to go outside. During an interview on 4/30/26 at 4:08 p.m., trained medication aide (TMA)-A stated R12 would wait by the door waiting for her son to come and pick her up. TMA-A stated the waiting by the door occurred mostly in the evenings after supper. During an interview on 4/30/26 at 4:14 p.m., LPN-A stated she had “caught” R12 a few times trying to leave the building, said she would usually come back in easily and then they would call her son. LPN-A stated R12 could walk independently using a walker, stated she would get between the doors, and the alarm would sound.			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 6 On 4/30/26 at 4:19 p.m., MA-B stated the manual identified electronics could potentially interfere with the functioning of the code alert system. All technology was removed from the dining area and the meeting room on either side of the main entrance door. MA-B proceeded to test the door; however, the door did not lock or alarm when approached with a code alert device. During an interview on 4/30/26 at 4:20 p.m., NA-F stated R12 would get things ready and say someone was coming to pick her up. NA-F stated R12 was able to walk around the building independently using her walker. During an interview on 4/30/26 at 4:25 p.m., LPN-B said R12 would try to leave the building about four to five times a week. LPN-B stated R12 get around the building independently using her walker. During an interview on 4/30/26 at 9:02 a.m., SC-D stated on 4/28 they had been at the nurse's station when R12 had set the door alarm off. Normally the door would have locked so R12 couldn't get through the first door. When they responded with another staff, R12 had already made it out between the doors. R12 said they were looking for the salon when we got her. During an interview on 4/30/26 at 4:29 p.m., SC-D stated Monday through Friday, she would be seated at the desk across from the front door from 8:00 a.m. to 4:30 p.m. The charge nurse would be responsible to lock the front door on the evening shift. SC-D stated R12 will try to leave the building, not usually as much as this week. SC-D recalled last summer R12 got between the two doors. SC-D stated R12 walked independently using a walker. During an interview on 5/1/26 at 3:38 p.m., the DON stated R12 has had increased confusion and behaviors regarding looking for and being worried about their son. It was a significant change in R12's disease progression for R12 to not know where their apartment was (that was what R12 called their room). The team had discussed R12's inability to navigate to their room and felt it would be beneficial to move R12 to a room where they did not have to pass the main entrance when going to and from their room. They planned to discuss the potential room change with R12's son. R3 was admitted on 9/25/25. R3's quarterly MDS assessment dated 4/9/26, indicated R4 was severely cognitively impaired with a diagnosis of dementia			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 7 neurocognitive Lewy body disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R4 had not exhibited wandering. R3's care plan last reviewed on 3/16/26 lacked interventions for elopement and wandering. R4 was admitted on 10/31/24. R4's quarterly MDS assessment dated 4/9/26, indicated R4 was severely cognitively impaired with diagnoses of Alzheimer's disease and non-traumatic brain dysfunction. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. indicated R4 had not exhibited wandering. R4's care plan last reviewed 4/6/26, lacked interventions for elopement and wandering. R13 was admitted on 1/10/24. R13's quarterly MDS assessment dated 4/17/26, indicated R13 was moderately cognitive impaired with the diagnoses of dementia, anxiety, and cognitive impairment. Section E900. did not identify wandering behavior. Section P. indicated a wander device was not in use. R13's care plan last revised 4/16/26, did not include elopement or wandering intervention. On 5/1/26, R13's elopement assessment was completed and R13's code alert device was removed. R17 was admitted on 7/29/25. R17's quarterly MDS dated 2/25/26, indicated R17 was moderately cognitively impaired with the diagnoses of dementia, and anxiety. Section E900. Indicated R17 had not exhibited wandering behavior. Section P. indicated a wander device was not in use. R17's care plan last updated 4/6/26, did not include elopement or wandering interventions. An Elopement assessment was completed on 5/1/26 and R17's code alert device was removed. R18 was admitted on 1/5/23. R18's quarterly MDS assessment dated 4/17/26, indicated R18 was moderately cognitively impaired with a diagnosis of Alzheimer's disease. MDS Section P. indicated a wander guard alarm was not in use. Section E900. indicated R18 had not exhibited wandering. R18's care plan was last reviewed 4/21/26, did not include interventions for elopement and wandering. R22 was admitted on 6/25/25. R22's quarterly MDS assessment dated 3/6/26, indicated R22 was severely cognitively impaired with diagnosis of vascular dementia with other behavioral disturbances. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. identified R22 had not exhibited wandering. R22's care plan last reviewed 3/5/26, lacked interventions for elopement and wandering and did not identify the placement location or R22's code alert device.			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 8 R23 was admitted on 4/6/26. R23's admission MDS dated 4/13/26, indicated R23 was severely cognitively impaired with the diagnoses of anxiety disorder, unspecified head injury and type 2 diabetes. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R23's care plan last reviewed on 4/28/26, lacked interventions for elopement and wandering. R28 was admitted on 5/16/23. R28's MDS assessment dated 3/20/26, indicated R28 was severely cognitively impaired with the diagnosis of dementia. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R28's care plan last reviewed on 4/6/26, lacked interventions for elopement and wandering. R32 was admitted on 10/3/16. R32's annual MDS assessment dated 2/13/26, indicated R32 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and dementia with behavior disturbances. MDS Section E0900. indicated R32 had not exhibited wandering behavior. Section P. did not indicate R32 had a wander guard. R32's care plan last reviewed 2/16/26, lacked interventions for elopement or wandering. R34 was admitted 1/8/21. R34's quarterly MDS dated 3/4/26, indicated R34 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and diabetes type 2. MDS Section E0900. indicated R34 had not exhibited wandering behavior. Section P. did not indicate R34 had a wander guard. R34's care plan last reviewed 4/5/26, lacked interventions for elopement and wandering. R37 was admitted 1/8/21. R37's quarterly MDS dated 3/26/26, indicated R37 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R37 had not exhibited wandering behavior. Section P. did not indicate R37 had a wander guard. The problem area elopement was not initiated on R37's care plan until 5/1/26. R46 was admitted on 2/26/21 and was discharged on 4/20/26. R46's significant change MDS assessment dated 3/18/26, indicated R46 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R46 had not exhibited wandering behavior. Section P. did not indicate R46 had a wander guard.			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 9 R46's care plan was requested but not received. On 4/30/26 at 4:19 p.m., MA-B stated the manual identified electronics could potentially interfere with the functioning of the code alert system. All technology was removed from the dining area and the meeting room on either side of the main entrance door. MA-B proceeded to test the door; however, the door did not lock or alarm when approached with a code alert device. During an interview on 4/30/26 at 4:20 p.m., NA-F stated R12 would get things ready and say someone was coming to pick her up. NA-F stated R12 was able to walk around the building independently using her walker. During an interview on 4/30/26 at 4:25 p.m., LPN-B said R12 would try to leave the building about four to five times a week. LPN-B stated R12 get around the building independently using her walker. During an interview on 4/30/26 at 9:02 a.m., SC-D stated on 4/28 they had been at the nurse's station when R12 had set the door alarm off. Normally the door would have locked so R12 couldn't get through the first door. When they responded with another staff R12 had already made it out between the doors. R12 said they were looking for the salon when we got her. During an interview on 4/30/26 at 4:29 p.m., SC-D stated Monday through Friday, she would be seated at the desk across from the front door from 8:00 a.m. to 4:30 p.m. The charge nurse would be responsible to lock the front door on the evening shift. SC-D stated R12 will try to leave the building, not usually as much as this week. SC-D recalled last summer R12 got between the two doors. SC-D stated R12 walked independently using a walker. During an interview on 5/1/26 at 3:38 p.m., the DON stated R12 has had increased confusion and behaviors regarding looking for and being worried about their son. It was a significant change in R12's disease progression for R12 to not know where their apartment was (that was what R12 called their room). The team had discussed R12's inability to navigate to their room and felt it would be beneficial to move R12 to a room where they did not have to pass the main entrance when going to and from their room. They planned to discuss the potential room change with R12's son. During an interview on 4/29/26 at 1:39 p.m., NA-G stated if a resident had wandering or elopement			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 10 risks that would be identified on the care plan. All staff watched for and redirected those behaviors. If a resident got too close to the main door, it locked and alarmed to alert staff to respond and redirect. Once the alarm went off it had to be reset to stop alarming and unlock the door. During an interview on 4/29/26 at 1:46 p.m., NA-B stated as a NA they didn't do anything with the code alert alarm devices on residents. The hydration NA went around once a week and checked to make sure the code alert devices were still working. During an interview on 4/29/26 at 1:54 p.m., NA-A stated another staff was the primary for testing resident code alert devices, but they had been trained and could do it if asked. During an interview on 4/29/26 at 2:14 p.m., licensed practical nurse (LPN-C) stated the facility kept a book of resident's who had code alert alarms at (SC)-D's desk by the main entrance. As an LPN, they were not assigned any assessments or checks for the code alert devices, the hydration NAs were the ones who went around and checked to make sure the devices were working. R3 had a code device on their ankle, and they were the only resident with ordered daily placement checks. During an interview on 4/30/26 at 11:41 a.m., RN-A stated residents got code alert devices placed if/when they were identified as having wandering/elopement behaviors and they could not be safe alone outside. The social worker was responsible for doing the wander/elopement assessments. There is always a concern a resident could elope because no system was fail proof. If a visitor went out the main door a resident could get out behind them. The alarm should go off if a resident makes it past the first door. NAs should know who has a code alert device and those residents should be watched closely. Wander and elopement risks should be added to the care plan with care interventions. Elopement attempts and behaviors should be documented in progress notes especially if the resident makes it out of the facility or past the first door. The NAs should also chart events in the behavior section of their charting. There should be progress notes about R12 and R19's attempts to leave. During an interview on 4/30/26 at 8:57 a.m., DPS-A said they had been called to check the main door. SC-D stated they had called DPS-A because they didn't see the yellow light sensor that meant the main door code alert system was working. DPS-A			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 11 held a resident code alert devise and walked to the main entry door and was able to walk into the vestibule between the outermost door and the inner door on the facility side of the vestibule. Once inside the vestibule, the inner door back into the facility locked. DPS-A could not get back into the facility until the alarm was reset. DPS-A explained the facility side door locked when the alarm was triggered. The Door to the outside of the building did not lock, so if a resident made it past the inside door into the vestibule, they would be able to proceed out of the building through the outer door. The system had adjustable sensors [canoes] on both sides of the doors that required adjustment so when a resident with an alert device got close to the door it would lock and if a resident made it through the first door or it was open, then the system alarmed. Humidity could affect the sensors as well as how they were set. DPS-A did a second system test. DPS-A walked up to the door and was able to make it through the first door. DPS-A stated the system hadn't locked the door because they had approached the door too quickly. DPS-A did a slower approach with the same result and then adjusted the canoes (sensors on either side of the door that sense the wearable dvice). DPS-A approached the door two more times, and the door locked appropriately both times. During a follow-up interview on 4/30/26 at 9:04 a.m., DPS-A stated the system had last been tested on 4/10/26. They had not been notified after R12 and R19 made it through the first door. If they had been notified the door would have been tested immediately. The facility did not have a formal notification or downtime plan for the code alert system. Maintenance numbers were posted, and they expected staff to call anytime there was a door malfunction. They came in on off hours to fix the door when needed. DPS-A binder showed their binder of manufacture manuals and testing logs. Logs indicated five doors were tested monthly. Upon review, DPS-A confirmed the Code Alert Monitoring System manual indicated that weekly door testing was optimal. DPS-A explained that when the main entrance door was working properly, the inside facility side door should lock when a resident got close. If the door was open and a resident was close to the door, then the alarm would go off. Once the door shut, the door would lock. The alarm would have to be reset for the door to unlock. Only the inside door locked, the door to outside was not part of the system, so that door opened regardless of the code alert system activation. During an interview on 4/30/26 at 4:00 p.m., the RS			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 12 Technologies Tech confirmed they serviced the code alert system. Manufacturer instructions should be followed for system testing, in addition, the company recommended yearly on-site system inspections be scheduled with RS technologies. On 4/30/26 at 4:29 p.m., MA-B and DPS-A had tech support on the phone and continued to adjust and test the main entrance door. The door was still not locking or alarming. DPS-A said they planned to have a tech come and service the door. SC-D stated they had been instructed to watch the door. On 4/30/26 at 4:39 p.m., MA-B performed function tests on all the code alert doors. The internal corridor door between the long-term care and short-term rehab failed two function tests. Both times the door did not lock when approached, MA-B was able to go through the door into the short-term rehab. The door alarm did go off as intended. The short-term rehab unit had a small entry area with a single door that went directly outside to the parking lot. MA-B tested the exit door twice. Both times the door failed to lock to prevent exit from the building. On 4/30/26 at 5:04 p.m., MA-B reported the short-term rehab doors had been fixed and were functioning properly. During an interview on 5/1/26 at 2:43 p.m. DPS-A stated they had spoken with a tech who had recommended they leave the main entrance door locked until the door could be serviced. They planned to keep the door locked until a tech was able to get on site to fix the door. A staff member would be stationed at SC-D's desk to let people in and out of the building until Monday. During an interview on 4/30/26 at 12:54 p.m., the DON stated they had not been made aware R12 and R19 had made it out the first door of the main entrance into the vestibule, but they had been present when R12 made it all the way outside, so they were aware of that. The DON stated when an event occurred the nurse should be notified, and then a progress note should be made if a resident makes it past a code alert door. They would expect notes to have been made about the events that occurred with R12 and R19. They would also like residents to be closely monitored after an event. Elopement assessments were reviewed quarterly. Assessments should be re-done if a resident had an event between quarterly assessments or a change from the last quarterly assessment. Resident care plans should include the location of the code alert device and resident specific elopement and			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 13 wandering interventions. They had a code alert book at the reception desk with a list of residents and their code alert device locations. Weekly code alert battery checks were recorded in the book. They did not do any other placement checks, or nursing assessments r/t code alert devices on a regular basis unless ordered. The DON stated they had never seen R12 ambulate without their walker but agreed residents who had the ability to ambulate without their assistive device potentially had a higher risk of elopement when the code alert was attached to their device instead of their person. During an interview on 4/30/26 at 1:14 p.m., LSW-A stated elopement risk assessments were done on admit determining if a resident should have a code alert device placed. New elopement assessments were not typically done after an attempt or elopement event if the resident already had a code alert device. However, a new quarterly elopement assessment would be done when due for any residents who had behavior changes or an event. Elopement behaviors and interventions do not get added to resident care plans, but that would be ideal. At present just the location of the code alert device like on walker etc. gets added to a problem area that is already on the care plan such as fall risk or cognition. During an interview on 4/30/26 at 2:08 p.m., the administrator stated they had not been notified of R19 and R12's attempts to exit the building. Leadership and maintenance should have been notified when R12 and R19 were able to get past the first door. They expected staff to notify maintenance anytime a door didn't seem to be functioning correctly so maintenance could service the door immediately. They had discussed the code alert system with DPS-A and decided they would start doing weekly door testing as recommended in the manual. The immediate jeopardy was removed on 5/1/26 at 4:36 p.m., when the facility scheduled maintenance for the call alert system, placed staff at the door to monitor the system at all times when the door was not locked, updated resident assessment and care plans for residents who used a code alert device, revised their Code Alert System policy, and educated staff on reporting failures in the call alert system. The facility policy Code Alert System dated 9/2017, identified the code alert transponder devices were to be tested weekly and the door function was to be tested by maintenance monthly. Malfunctions or repairs made were to be reported to the			F0689			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 14 administrator and nursing along with the current status of the system and need for special monitoring due to delay in repairs. The policy did not address malfunctions and actions to be taken for malfunctions outside of monthly testing. Nor did it address down time procedures for malfunction of the system or doors. The facility policy Elopement dated 1/2023, identified residents known to wander and or who have cognitive deficits may wear the signaling device which activates an alarm should they leave the facility. Staff instruction for resident elopement was outlined in the policy. The policy did not include instruction to staff for reporting code alert system malfunctions or alternative actions to be implemented during code system malfunctions.			F0689			06/09/2026
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than			F0641	It is the policy of St. Clare Living Community to ensure accurate MDS coding to develop person centered care plans for residents who are at risk for wandering, and elopement. Policies for comprehensive person-centered care plans were reviewed and revised. For residents R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46 elopement assessments, and care plans were completed on 5/1/2026. For all other like residents elopement assessments and care plans were reviewed/updated as appropriate. The Nursing department was re-educated on elopement assessments, MDS sections E & P, person centered care plans, & policies pertaining to MDS's, care plans, and elopement/wandering on 5/27/26, & 5/28/2026. Elopement assessments, care plans, and sections E&P audit will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The facility will continue to provide ongoing education/training for new employees and current staff. This education will be present via live all staff in-services, policy review/updates in written form, and facility on-line education program Health Care Academy. The Director of Nursing or designee will be responsible for compliance.		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0641 SS = E	Continued from page 15 \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure accurate MDS coding of the use of a code alert device occurred for 14 of 14 residents (R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, R46) who were identified as at risk for elopement and wandering. Findings include: The code alert system log titled Wander Guard Monitor dated 4/2026, identified the following 14 residents as having a code alert device: R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46. R3 was admitted on 9/25/25. R3's quarterly MDS assessment dated 4/9/26, indicated R4 was severely cognitively impaired with a diagnosis of dementia neurocognitive Lewy body disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R4 had not exhibited wandering. R3's care plan last reviewed on 3/16/26 lacked interventions for elopement and wandering. R4 was admitted on 10/31/24. R4's quarterly MDS assessment dated 4/9/26, indicated R4 was severely cognitively impaired with diagnoses of Alzheimer's disease and non-traumatic brain dysfunction. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. indicated R4 had not exhibited wandering. R4's care plan last reviewed 4/6/26, lacked interventions for elopement and wandering. R13 was admitted on 1/10/24. R13's quarterly MDS assessment dated 4/17/26, indicated R13 was moderately cognitive impaired with the diagnoses of dementia, anxiety, and cognitive impairment. Section E900. did not identify wandering behavior. Section P. indicated a wander device was not in use. R13's care plan last revised 4/16/26, did not include elopement or wandering intervention. On 5/1/26, R13's elopement assessment was completed and R12's code alert device was removed. R17 was admitted on 7/29/25. R17's quarterly MDS dated 2/25/26, indicated R17 was moderately cognitively impaired with the diagnoses of dementia, and anxiety. Section E900. Indicated R17 had not exhibited wandering behavior. Section P. indicated a			F0641			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0641 SS = E	Continued from page 16 wander device was not in use. R17's care plan last updated 4/6/26, did not include elopement or wandering interventions. An Elopement assessment was completed on 5/1/26 and R17's code alert device was removed. R18 was admitted on 1/5/23. R18's quarterly MDS assessment dated 4/17/26, indicated R18 was moderately cognitively impaired with a diagnosis of Alzheimer's disease. MDS Section P. indicated a wander guard alarm was not in use. Section E900. indicated R18 had not exhibited wandering. R18's care plan was last reviewed 4/21/26, did not include interventions for elopement and wandering. R22 was admitted on 6/25/25. R22's quarterly MDS assessment dated 3/6/26, indicated R22 was severely cognitively impaired with diagnosis of vascular dementia with other behavioral disturbances. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. identified R22 had not exhibited wandering. R22's care plan last reviewed 3/5/26, lacked interventions for elopement and wandering and did not identify the placement location or R22's code alert device. R23 was admitted on 4/6/26. R23's admission MDS dated 4/13/26, indicated R23 was severely cognitively impaired with the diagnoses of anxiety disorder, unspecified head injury and type 2 diabetes. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R23's care plan last reviewed on 4/28/26, lacked interventions for elopement and wandering. R28 was admitted on 5/16/23. R28's MDS assessment dated 3/20/26, indicated R28 was severely cognitively impaired with the diagnosis of dementia. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R28's care plan last reviewed on 4/6/26, lacked interventions for elopement and wandering. R32 was admitted on 10/3/16. R32's annual MDS assessment dated 2/13/26, indicated R32 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and dementia with behavior disturbances. MDS Section E0900. indicated R32 had not exhibited wandering behavior. Section P. did not indicate R32 had a wander guard. R32's care plan last reviewed 2/16/26, lacked interventions for elopement or wandering. R34 was admitted 1/8/21. R34's quarterly MDS			F0641			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0641 SS = E	Continued from page 17 dated 3/4/26, indicated R34 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and diabetes type 2. MDS Section E0900. indicated R34 had not exhibited wandering behavior. Section P. did not indicate R34 had a wander guard. R34's care plan last reviewed 4/5/26, lacked interventions for elopement and wandering. R37 was admitted 1/8/21. R37's quarterly MDS dated 3/26/26, indicated R37 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R37 had not exhibited wandering behavior. Section P. did not indicate R37 had a wander guard. The problem area elopement was not initiated on R37's care plan until 5/1/26. R46 was admitted on 2/26/21, and was discharged on 4/20/26. R46's significant change MDS assessment dated 3/18/26, indicated R46 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R46 had not exhibited wandering behavior. Section P. did not indicate R46 had a wander guard. R46's care plan was requested but not received. R19 was admitted to the facility on 5/8/2017. R19' significant change MDS assessment dated 2/16/26, indicated R19 was severely cognitively impaired with the diagnosis of Alzheimer's disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R19 had not exhibited wandering. R19's care plan reviewed 2/10/26, lacked interventions for elopement and wandering. R19's most recent elopement assessment was completed on 2/9/26. The assessment identified R19 as low risk for elopement and interventions included clothing labeled with identification, identification band on resident. The Door Alarm band applied (code alert device) was not selected. R19's EMR lacked evidence to show elopement assessments had been performed quarterly. R12 was admitted to the facility on 10/9/23. R12's quarterly MDS assessment dated 4/29/26, indicated R12 was severely cognitively impaired with diagnoses of non-Alzheimer's dementia and anxiety. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R12 had not exhibited wandering. R12's care plan last reviewed 4/16/26, lacked interventions for elopement and wandering. R12 had documented elopement assessments			F0641			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0641 SS = E	Continued from page 18 completed by the licensed social worker (LSW-A) on 10/27/23, 9/15/24, 8/18/25. R12's most recent assessment completed on 8/18/25, indicated R12 was a low risk for elopement and interventions in place included: clothing labeled, and an identification band placed on the wrist. The door alarm had applied (code alert device) was not selected as an intervention. R12's EMR lacked evidence quarterly elopement assessments had been completed. Progress notes entered by LSW-A on 10,30/25, 1/22/26, and 4/16/26, indicated R12's elopement assessments had been reviewed with no change. R12's EMR lacked documentation regarding R12's successful exit of the building on 4/30/26, or their attempts to exit the building made on 4/28/26, and 5/1/26. During an interview on 4/29/26 at 1:39 p.m., NA-G stated if a resident had wandering or elopement risks that would be identified on the care plan. During an interview on 4/29/26 at 2:14 p.m., LPN-C stated the facility kept a book of resident's who had code alert alarms at SC-D's desk by the main entrance. As an LPN, they were not assigned any assessments or checks for the code alert devices. During an interview on 4/30/26 at 9:26 a.m., registered nurse (RN)-B verified section P of the quarterly MDS dated 3/13/26, did not identify R3 had a wanderguard in use. RN-B stated they "never code them". RN-B stated she saw there was a wanderguard in use from reviewing the nursing assistant group sheets but again said they have never coded the wanderguards. RN-B stated the purpose of the MDS was to identify payment, create a picture of all aspects of the resident's life and stated it would help in creating a care plan for the resident(s). During an interview on 4/30/26 at 11:41 a.m., RN-A stated residents got code alert devices placed if/when they were identified as having wandering/elopement behaviors and they could not be safe alone outside. Wander and elopement risks should be added to the care plan with care interventions. Elopement attempts and behaviors should be documented in progress notes especially if the resident made it out of the facility or past the first door. The NAs should also chart events in the behavior section of their charting. The MDS nurse could access behavior charting and the care plan to know who had code alert.			F0641			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0641 SS = E	Continued from page 19 During an interview on 4/30/26 at 12:54 p.m., the DON stated elopement assessments were reviewed quarterly. Assessments should be re-done if a resident had an event between quarterly assessments or a change from the last quarterly assessment. Resident care plans should include the location of the code alert device and resident specific elopement and wandering interventions. The MDS should be coded to reflect code alert placement because MDS drives the care/care plan. The undated, facility policy Care Planning-IDT identified the care plan was based on the resident's comprehensive MDS assessment. MDS policies were requested but not received.			F0641			06/09/2026
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired			F0656	It is the policy if St. Clare Living Community to develop comprehensive care plan with individualized interventions for wandering, elopement, antidepressants, smoking, and enhanced barrier precautions. Policies for comprehensive person-centered care plans were reviewed and revised. For residents R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46 elopement assessments, and care plans were completed on 5/1/2026. For residents R7, R14, & R26 care plans for antidepressants, smoking, and enhanced barrier precautions were initiated 5/2/26, 5/18/26, & 4/30/26. For all other like residents care plans were reviewed/revised as appropriate. Nursing staff were re-educated on person centered care plans with individualized interventions on 5/27/26 & 5/28/26. Care plan & CNA assignment sheet audits will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The facility will continue to provide ongoing education/training for new employees and current staff. This education will be present via live all staff in-services, policy review/updates in written form, and facility on-line education program Health Care Academy. The Director of Nursing or designee will be responsible for compliance.		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 20 outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan with individualized elopement and wandering interventions with review and revision after subsequent MDS assessments or elopement status changes for 14 of 14 residents (R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, R46) who were identified as at risk for elopement and wandering. In addition, the facility failed to care plan necessary interventions for 3 of 3 residents (R7, R14, and R26) who were addressed for care planning. Findings include: The code alert system log titled Wander Guard Monitor dated 4/2026, identified 14 residents who had code alert devices: R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46. R3 was admitted on 9/25/25. R3's quarterly MDS assessment dated 4/9/26, indicated R4 was severely cognitively impaired with a diagnosis of dementia neurocognitive Lewy body disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R4 had not exhibited wandering. R3's care plan last reviewed on 3/16/26 lacked interventions for elopement and wandering. R4 was admitted on 10/31/24. R4's quarterly MDS assessment dated 4/9/26, indicated R4 was severely cognitively impaired with diagnoses of Alzheimer's disease and non-traumatic brain dysfunction. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. indicated R4 had not exhibited wandering. R4's care plan last reviewed 4/6/26, lacked interventions for elopement and wandering.			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 21 R13 was admitted on 1/10/24. R13’s quarterly MDS assessment dated 4/17/26, indicated R13 was moderately cognitive impaired with the diagnoses of dementia, anxiety, and cognitive impairment. Section E900. did not identify wandering behavior. Section P. indicated a wander device was not in use. R13's care plan last revised 4/16/26, did not include elopement or wandering intervention. On 5/1/26, R13’s elopement assessment was completed and R13’s code alert device was removed. R17 was admitted on 7/29/25. R17’s quarterly MDS dated 2/25/26, indicated R17 was moderately cognitively impaired with the diagnoses of dementia, and anxiety. Section E900. Indicated R17 had not exhibited wandering behavior. Section P. indicated a wander device was not in use. R17’s care plan last updated 4/6/26, did not include elopement or wandering interventions. An Elopement assessment was completed on 5/1/26 and R17’s code alert device was removed. R18 was admitted on 1/5/23. R18’s quarterly MDS assessment dated 4/17/26, indicated R18 was moderately cognitively impaired with a diagnosis of Alzheimer’s disease. MDS Section P. indicated a wander guard alarm was not in use. Section E900. indicated R18 had not exhibited wandering. R18’s care plan was last reviewed 4/21/26, did not include interventions for elopement and wandering. R22 was admitted on 6/25/25. R22’s quarterly MDS assessment dated 3/6/26, indicated R22 was severely cognitively impaired with diagnosis of vascular dementia with other behavioral disturbances. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. identified R22 had not exhibited wandering. R22’s care plan last reviewed 3/5/26, lacked interventions for elopement and wandering and did not identify the placement location or R22’s code alert device. R23 was admitted on 4/6/26. R23’s admit MDS dated 4/13/26, indicated R23 was severely cognitively impaired with the diagnoses of anxiety disorder, unspecified head injury and type 2 diabetes. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R23’s care plan last reviewed on 4/28/26, lacked interventions for elopement and wandering. R28 was admitted on 5/16/23. R28’s MDS assessment dated 3/20/26, indicated R28 was severely cognitively impaired with the diagnosis of			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 22 dementia. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R28's care plan last reviewed on 4/6/26, lacked interventions for elopement and wandering. R32 was admitted on 10/3/16. R32's annual MDS assessment dated 2/13/26, indicated R32 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and dementia with behavior disturbances. MDS Section E0900. indicated R32 had not exhibited wandering behavior. Section P. did not indicate R32 had a wander guard. R32's care plan last reviewed 2/16/26, lacked interventions for elopement or wandering. R34 was admitted 1/8/21. R34's quarterly MDS dated 3/4/26, indicated R34 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and diabetes type 2. MDS Section E0900. indicated R34 had not exhibited wandering behavior. Section P. did not indicate R34 had a wander guard. R34's care plan last reviewed 4/5/26, lacked interventions for elopement and wandering. R37 was admitted 1/8/21. R37's quarterly MDS dated 3/26/26, indicated R37 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R37 had not exhibited wandering behavior. Section P. did not indicate R37 had a wander guard. The problem area elopement was not initiated on R37's care plan until 5/1/26. R46 was admitted on 2/26/21, and discharged from the facility on 4/20/26. R46's significant change MDS assessment dated 3/18/26, indicated R46 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R46 had not exhibited wandering behavior. Section P. did not indicate R46 had a wander guard. R46's care plan was requested but not received. R19 was admitted to the facility on 5/8/2017. R19' significant change MDS assessment dated 2/16/26, indicated R19 was severely cognitively impaired with the diagnosis of Alzheimer's disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R19 had not exhibited wandering. R19's care plan reviewed 2/10/26, lacked interventions for elopement and wandering. R19's most recent elopement assessment was completed on 2/9/26. The assessment identified R19 as low risk for elopement and interventions included			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 23 clothing labeled with identification, identification band on resident. The Door Alarm band applied (code alert device) was not selected. R12's quarterly MDS assessment dated 4/29/26, indicated R12 was severely cognitively impaired with diagnoses of non-Alzheimer's dementia and anxiety. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R12 had not exhibited wandering. R12's care plan last reviewed 4/16/26, lacked interventions for elopement and wandering. R12 had documented elopement assessments completed by the licensed social worker (LSW-A) on 10/27/23, 9/15/24, 8/18/25. R12's most recent assessment completed on 8/18/25, indicated R12 was a low risk for elopement and interventions in place included: clothing labeled, and an identification band placed on the wrist. The door alarm bad applied (code alert device) was not selected as an intervention. During an interview on 4/29/26 at 1:39 p.m., NA-G stated if a resident had wandering or elopement risks that would be identified on the care plan. All staff watched for and redirected those behaviors. During an interview on 4/30/26 at 11:41 a.m., registered nurse (RN-A) stated residents got code alert devices placed if/when they were identified as having wandering/elopement behaviors and they could not be safe alone outside. NAs should know who has a code alert device and those residents should be watched closely. It was the licensed social worker's (LSW-A) responsibility to complete Elopement risk assessments. If nurses initiated a code alert device they would then notify the SW to complete the assessment. Devices were typically placed on resident assistive devices like wheelchairs, walkers, or canes. Once a week the hydration NA went around and checked each device battery to make sure it was still working. There were no other routine nursing assessments or placement checks done associated with the code alerts by nursing. R3 was the only resident with an ankle placement and ordered daily placement checks. Wander and elopement risks should be added to the care plan with care interventions. Elopement attempts and behaviors should be documented in progress notes especially if the resident made it out of the facility or past the first door. The NAs should also chart events in the behavior section of their charting. There should be progress notes about R12 and R22's attempts to leave. The MDS nurse and the social worker have access to the behavior			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 24 charting. During an interview on 4/30/26 at 12:54 p.m., the DON stated elopement assessments were reviewed quarterly. Assessments should be re-done if a resident had an event between quarterly assessments or a change from the last quarterly assessment. Resident care plans should include the location of the code alert device and resident specific elopement and wandering interventions. Residents who eloped or exhibited wandering or elopement behaviors, and or had had lower cognition or other risk factors that put that at risk if they were to leave the building were assigned code alert devices. It was LSW's responsibility to complete the elopement assessments. Nurses had the ability to place a code alert device and then notify the LSW an assessment needed to be completed. The DON stated they were not sure if a new assessment was completed if a resident eloped or attempted to leave like R12 and R19 had. The MDS should be coded to reflect code alert placement because it drives the care plan and care. During an interview on 4/30/26 at 1:14 p.m., LSW-A stated they were responsible for completing elopement risk assessments. Assessments were done on admit to determine if a resident should have a code alert device placed. Assigning low, medium or high risk for elopement was a judgment call, there was not criteria or a tool for assigning a risk level. New elopement assessments were not typically done after an attempt or elopement event if the resident already had a code alert device. However, a new quarterly elopement assessment would be done when due for any residents who had behavior changes or an event. Elopement behaviors and interventions did not get added to resident care plans, but that would be ideal. At present just the location of the code alert device like on walker etc. gets added to a problem area that is already on the care plan such as fall risk or cognition. The facility policy Elopement dated 1/2023, identified residents known to wander and or who have cognitive deficits may wear the signaling device which activates an alarm should they leave the facility. Staff instruction for resident elopement was outlined in the policy. The policy did not address elopement assessment completion or frequency. The undated, facility policy Care Planning -IDT instructed a comprehensive care plan was to be developed within seven days of completion of the MDS.			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 25 The facility policy Code Alert System dated 9/2017 procedure section instructed nurses to perform resident assessment of ambulation, cognitive reasoning, and mental capacity. Residents identified as at risk will have potential risk for elopement addressed in the care plan and a code alert transponder applied to person or device. R7: R7's quarterly Minimum Data Set (MDS) dated 4/15/26, identified he was moderately cognitively intact and had diagnoses which included heart failure (a chronic condition where the heart muscle cannot pump blood effectively to meet the body's needs for oxygen), diabetes mellitus, anemia, insomnia, and chronic atrial fibrillation (a heart arrhythmia where the upper chambers of the heart beat rapidly and irregularly). In addition, R7's MDS identified he was taking an antidepressant. R7's current physician order report dated 4/1/26-4/30/26, identified R7 was on the following medication: Trazadone 50 milligrams (mg), instructions identified to take at bedtime for sleep disturbance started on 1/21/26. R7's care plan dated 1/8/26, did not address sleep disturbance or antidepressant use. R7's electronic medication record dated 4/1/26-4/30/26, identified R7 received trazadone every night except 4/30/26. During an interview on 4/30/26 at 9:23 a.m., registered nurse (RN)-A reviewed the electronic medical record and verified there was nothing documented in R7's care plan for sleep or antidepressant use. RN-A stated it was important to have this information in the care plan to guide staff in caring for the resident. R14: R14's quarterly MDS dated 2/11/26, identified R14 was moderately cognitively intact and had diagnoses which included chronic obstructive pulmonary disease (COPD [a lung condition that causes long-term breathing problems by limiting air flow]), heart failure, tobacco use, Alzheimer's, chronic cough, and panlobular emphysema (a severe chronic, and irreversible type of COPD). In addition, R14's MDS identified verbal behaviors and rejection of care.			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 26 R14's nursing assistant group sheet, dated 4/28/26, did not identify she smoked. R14's care plan dated 2/11/26, did not address smoking. During an observation on 4/27/26 at 3:30 p.m., R14 was wheeled out the front door by staff, she sat in her wheelchair just outside the front door and smoked a cigarette. During an observation on 4/27/26 at 4:45 p.m., R14 was brought out the front door by staff where she smoked a cigarette. During an interview on 4/30/26 at 8:59 a.m., registered nurse (RN)-A stated the resident care plans should be updated as part of the care conference. RN-A stated the facility did allow residents to smoke and said they did accept residents who smoked. RN-A reviewed R14's care plan and verified there was nothing in the care plan that addressed smoking for R14. During an interview on 4/30/26 at 9:39 a.m., the director of nursing (DON) verified they did allow residents to smoke and stated it should have been addressed in the care plan. The DON stated it was important for staff to know if a resident smoked for safety considerations. During an interview on 4/30/26 at 10:15 a.m., nursing assistant (NA)-B reviewed the group sheet for R14 and verified there was nothing to identify she smoked. Smoking Policy-Residents dated 3/2025, identified the facility would establish and maintain safe resident and smoking practices. The policy identified the resident's ability to smoke safely would be re-evaluated quarterly and upon a significant change. R26: R26's annual MDS dated 3/6/26, identified he was cognitively intact and had diagnoses which included hypertension, chronic kidney disease stage 5 with dependence on renal dialysis (a life-sustaining medical treatment that filters waste products, toxins, and excess fluids from the blood when the kidneys have failed), diabetes mellitus, chronic pain, morbid obesity, anxiety, COPD, cardiac pacemaker, and depressive disorder. In addition, R26's MDS identified he was receiving dialysis services.			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = E	Continued from page 27 R26's nursing assistant group sheet, dated 4/28/26, did not identify in the safety column that he was on enhanced barrier precautions. During an interview on 4/30/26 at 9:37 a.m., the DON stated she would need to check with the infection preventionist to see if R26 needed to be in enhanced barrier precautions (EBP) based on his dialysis access site. The DON stated EBP would be used to protect any resident who had a wound, catheter, tube feeding, or a peripheral inserted central catheter. During an interview on 4/30/26 at 10:12 a.m., the infection preventionist (IP) reviewed R26's care plan and verified EBP were not part of the care plan. The IP stated she would expect a resident with a Quinton catheter (a large-bore, double-lumen central venous catheter designed for rapid blood flow in hemodialysis) to be in EBP and part of the care plan. The IP stated EBP are meant to protect the resident from infection. During an interview on 4/30/26 at 10:15 a.m., NA-B stated R26 should be in EBP and staff should be gowning up to perform any hands-on care. Enhanced Barrier Precautions dated 4/2024, identified the purpose of EBP was to reduce the spread of multidrug resistant organisms (MDRO). The policy identified EBP should be used if a resident had an indwelling medical device regardless of MDRO colonization. The policy identified EBP would be used during high contact resident care activities. Care Plans, Comprehensive Person-Centered Care no date, identified the plan would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. In addition, the plan would be developed from a thorough analysis of the information gathered as part of the comprehensive assessment. During an interview on 4/30/26 at 12:37 p.m., the DON stated the care plans should be addressed quarterly with the care conference and they should include information about smoking, wanderguard use, enhanced barrier precautions, and medication use (including use of an antidepressant). The DON stated this was important for direct care staff to have the information for safety, quality of life, and to address their needs and preferences for care.			F0656			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must			F0880	It is the policy of St. Clare Living Community of Mora to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. St. Clare Living Community failed to ensure proper hand hygiene and use of an ice scoop was followed during the snack/hydration pass. Hand hygiene policy was reviewed/revised on 5/19/2026 & includes procedure for snack & hydration pass. Nursing staff were re-educated on hand hygiene policy on 5/27/26 & 5/28/26. For all residents affected by this practice hand hygiene audits will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The facility will continue to provide ongoing education/training for new employees and current staff. This education will be present via live all staff in-services, policy review/updates in written form, and facility on-line education program Health Care Academy. The Director of Nursing or designee will be responsible for compliance.		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0880 SS = E	Continued from page 29 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene and use of an ice scoop was followed during the snack pass. This deficient practice affected 3 of 3 residents (R29, R30, R7) and any other residents who received snacks during the snack pass. Finding include: R29's comprehensive Minimum Data Set (MDS) dated 2/16/26, identified she was moderately cognitively intact and had diagnoses which included heart disease, hypertension, hyperlipidemia, and gastroesophageal reflux disease. R30's quarterly MDS dated 4/13/26, identified she was moderately cognitively intact and had diagnoses which included heart failure (a chronic serious condition in which the heart muscle cannot pump enough blood to meet the body's needs for oxygen), diabetes mellitus and depression. R7's quarterly MDS dated 4/20/26, identified he was moderately cognitively intact and had diagnoses which included heart failure and diabetes mellitus. During an observation on 4/29/26 at 1:56 p.m., nursing assistant (NA)-A had a snack cart with two			F0880			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0880 SS = E	Continued from page 30 over-sized plastic pitchers filled with ice. NA-A stopped the cart outside of R29's room, NA-A was not wearing gloves entered the room, brought out the water cup, filled the water cup with ice using a plastic water glass, NA-A put the plastic glass back into the over-sized pitcher with ice, exited the room and did not perform hand hygiene. NA-A proceeded to R7's room and did not perform hand hygiene, entered the room brought out the water cup filled it with ice using the plastic water glass that was resting on top of the ice, poured juice into a cup, brought the water cup, the juice, a bag of chips and brought the items into R7's room. NA-A exited the room; no hand hygiene was performed. NA-A went into R30's room after knocking asked if they wanted any snacks, exited the room with a plate with food on it and put the plate and food into the garbage bag attached to the snack cart. NA-A did not perform hand hygiene, picked up a banana and brought it into R30's room, exited the room. No hand hygiene was performed. During an interview on 4/29/26 at 2:01 p.m., NA-A stated they took the snack cart around to rooms twice daily. NA-A verified she would put the plastic water glass back into the over-sized pitcher with ice and stated, "it doesn't touch anything". NA-A verified they did not perform hand hygiene before or after exiting resident rooms or after disposing of uneaten food removed from R30's room. During an interview on 4/30/26 at 9:42 a.m., the director of nursing (DON) stated she would expect staff to perform hand hygiene before entering and after exiting a resident room. The DON stated using a plastic water glass to fill water cups coming from resident rooms and then putting the plastic water cup back into the over-sized ice pitcher was an infection control concern. Hand Hygiene dated 6/2019, identified all employees would be trained on hand hygiene practices. The policy identified hand hygiene would be performed before and after handling food and after handling soiled utensils or equipment.			F0880			06/09/2026
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1)			F0561	It is the policy of St. Clare Living Community of Mora to promote and facilitate resident self determination through support of resident choice. Self Determination policy was reviewed, and Nail Care policy developed. For resident R8 nails were trimmed, and weekly fingernail & toenail nursing order was added. 100% of residents nail care orders were reviewed and added as appropriate and coincide with resident bath day. Nursing staff were re-educated		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0561 SS = D	Continued from page 31 through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure resident preferences for nail care were honored for 1 of 1 resident (R8). Findings include: R8's annual Minimum Data Set (MDS) assessment dated 3/27/26, indicated R8 was moderately cognitively impaired with the diagnoses of non-Alzheimer's dementia, renal insufficiency, hypertension, and depression. R8's care plan last reviewed 3/26/26 indicated R8 had limited range of motion in their upper extremities and required an assist of 1 for daily bathing, weekly showers, daily grooming, oral care, and dressing. R8's progress notes indicated R8 had last had a shower on 4/3/26. Nail care was not addressed in progress notes. During an observation on 4/28/26 at 12:48 p.m., R8 was seated in wheelchair in room with their tv remote partially on their bedside table between their hands. Noted tremor in both hands, fingernails were			F0561	Continued from page 31 on updated nail care policy on 5/27/26 &5/28/26. Nail care audits will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The facility will continue to provide ongoing education/training for new employees and current staff. This education will be present via live all staff in-services, policy review/updates in written form, and facility on-line education program Health Care Academy. The Director of Nursing or designee will be responsible for compliance.		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0561 SS = D	Continued from page 32 long beyond tips of fingers. R8 stated they were trying to get their remote onto the bedside table, but their hands were so bad they couldn't do it. There was a nail clipper on the left side of R8's bedside table. R8 stated they had the nail clipper there because they wanted to have their nails trimmed, they were too long. R8 stated they couldn't trim their nails, so they had asked staff, but nobody had done it so far. During an interview on 4/29/2026 at 8:57 a.m., R8 stated staff had trimmed their nails before, but nobody had trimmed them yet. It bothered them to have their nails so long. On 4/30/26 at 11:22 a.m., R8 was seated in wheelchair in room the nail clipper was still on the bedside table. R8 stated they know I want my nails trimmed but nobody has done it yet. During an interview on 4/29/26 at 2:14 p.m., licensed practical nurse (LPN-C) stated all residents should have nail care offered on shower day. Nursing assistants (NA) do nail care unless the resident is a diabetic or has some other considerations, then the nurse would do the nail care on bath day. During an interview on 4/29/26 at 1:29 p.m., NA-J stated typically we do nail care on bath days but if a resident wanted their nails trimmed either the NA or the nurse should do it. 04/29/2026 1:39 p.m., NA-G 3 stated NAs could do nail care for R8. Activities did a spa day group so R8 could get their nails done in group, otherwise fingernails got done on bath days. 04/29/2026 1:46 p.m., NA-B stated NAs could cut fingernails on most residents including R8. Every room also had an activities calendar. Residents can see when they can go to group and get their nails done by activities. During an interview on 4/30/26 at 11:41 a.m., registered nurse (RN-B) stated both nursing assistant and wellness staff (they are NAs) can trim nails. R8 can have either trim their nails. Regardless of what day it is, if a resident requests to have their nails trimmed, their nails should be trimmed. If the NAs can't do it, then they should get the nurse to do it. During an interview on 4/30/26 at 12:52 p.m., the director of nursing (DON) stated nail trimming was typically done on shower days, but if a resident was			F0561			06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2026	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET , MORA, Minnesota, 55051			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0561 SS = D	Continued from page 33 requesting to have their nails trimmed on a different day, she would expect staff to trim those nails. A resident should not have to wait until their next bath day to get their nails trimmed. The facility policy Resident Choice Policy & Procedure dated 5/2/26, identified autonomy and self-determination were fundamental to quality of life and dignity. The facility would provide a supportive environment that encouraged and facilitated resident choice, respected individual preferences and needs to the greatest extent possible consistent with safety and regulations. The undated facility policy Fingernails-Cleaning and Trimming provided instruction on how to complete nail care and instructed nursing staff will provide nail care as necessary to residents.			F0561			06/09/2026