

### Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245291 August 12, 2015

Mr. Jack L'Heureux, Administrator St Clare Living Community Of Mora 110 North Seventh Street Mora, Minnesota 55051

Dear Mr. L'Heureux:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 4, 2015 the above facility is certified for or recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 12, 2015

Mr. Jack L'Heureux, Administrator St. Clare Living Community of Mora 110 North Seventh Street Mora, Minnesota 55051

RE: Project Number S5291024

Dear Mr. L'Heureux:

On July 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 10, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 4, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2015, effective August 4, 2015 and therefore remedies outlined in our letter to you dated July 14, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: B20W

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	Γ I - TO BE COMPLETED B	Y THE STAT	STATE SURVEY AGENCY Facility ID: 00814			
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245291  2.STATE VENDOR OR MEDICAID NO. (L2) 064628999	3. NAME AND ADDRESS OF FAC (L3) ST CLARE LIVING COM (L4) 110 NORTH 7TH STREE	MUNITY OF		4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW		
(L2) <b>064628000</b> 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) <b>02/01/2011</b>	(L5) MORA, MN  7. PROVIDER/SUPPLIER CATECON 01 Hospital 05 HHA	09 ESRD	(L6) 55051  02 (L7)  13 PTIP 22 CLIA	5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY <b>08/10/2015</b> (L34)  8. ACCREDITATION STATUS: (L10)  0 Unaccredited	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12. Total Facility Beds 65 (L18)  13. Total Certified Beds 65 (L17)	10.THE FACILITY IS CERTIFIED  X A. In Compliance With  Program Requirements  Compliance Based On: 1. Acceptable POC  B. Not in Compliance with Pro  Requirements and/or App	ogram	And/Or Approved Waivers Of The  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code  * Code: A*	6. Scope of Services Limit 7. Medical Director		
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  65 (L37) (L38) (L39)	ICF III (L42) (L42)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE	SHOW LTC CANCELLATION DATE	):				
Brenda Fischer, Unit Superviso	Date : 08/10/2015	(L19)	Kate JohnsTon, Pro			
PART II - TO  19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate  2. Facility is not Eligible  (L21)	20. COMPLIANCE WIT RIGHTS ACT:			al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE 23. LTC AGREEM  OF PARTICIPATION BEGINNING  09/01/1985  (L24) (L41)			26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimbursemer  03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE:  27. ALTERNATIV  A. Suspension  (L27)  B. Rescind Su	of Admissions: (L44)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
28. TERMINATION DATE: 2 (L28)	9. INTERMEDIARY/CARRIER NO. 03001	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539 3 (L32)	2. DETERMINATION OF APPROVAL 08/07/2015	DATE (L33)	Posted 09/01/2015 C			

Form Approved
OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245291	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/10/2015	
Name	of Facility		Street Address, City, State, Zip Code		
ST CLARE LIVING COMMUNITY OF MORA			110 NORTH 7TH STREET		
-			MORA, MN 55051		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0241		08/04/2015		ID Prefix	F0309		08/04/2015		ID Prefix	F0315		08/04/2015
Reg. #	483.15(a)				Reg. #	483.25				Reg.#	483.25(d)		
LSC			-		LSC			-		LSC			_
			•	<del>                                     </del>				•					
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0323		08/04/2015		ID Prefix	F0465		08/04/2015		ID Prefix			Completed
Rea.#	483.25(h)				Rea.#	483.70(h)				Reg. #			
LSC			-		LSC								_
			•	<del>                                     </del>				•	+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			_		ID Prefix			_		ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC			-		LSC			_					_
			<del>-</del>					•					_
			Correction					Correction					Correction
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LSC			=		LSC			_		LSC			_
			-	-				•					
Reviewed By	/	Reviewed I	Ву	Da	te:	Signature o	of Surve	yor:				Date:	
State Agency	у	BF/	KJ	08/	/12/201	5		1056	52			08/1	0/2015
Reviewed By	,	Reviewed I	Ву	Dat	te:	Signature of	of Surve	yor:				Date:	
CMS RO													
Followup to	Survey Comple	ted on:				Check	for any	Uncorrected	Defici	encies Was	a Summary of	-	
•	6/25/2				<del></del>		-				to the Facility?	YES	NO
	0,2012			1								0	

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: B20W

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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5. EFFECTIVE DATE CHANGE OF OWN (L9) 02/01/2011 6. DATE OF SURVEY 06/25/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC		7. PROVIDER/SUP 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEGOR 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	Y 09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 14 CORF	22 CLIA	7. On-Site Visit  8. Full Survey After Co  FISCAL YEAR ENDING  09/30	
2 AOA 3 Other  11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds  14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 65	65 (L18) 65 (L17)	X B. Not in Comp Requirement	cee With quirements Based On: ccceptable POC  pliance with Programents and/or Applied	n	2. Tr 3. 2. 4. 7. 5. L * Code:	echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code  B*	- Following Requirements:  6. Scope of Service 7. Medical Direct 8. Patient Room it 9. Beds/Room  (L12)	tor
(L37) (L38)  16. STATE SURVEY AGENCY REMARKS  17. SURVEYOR SIGNATURE	STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
Mardelle Trettel,			07/29/2015 D BY HCFA RI	(L19)	Kate JohnsTon, Program Specialist 08/04/2015 (L20)  AL OFFICE OR SINGLE STATE AGENCY			
DETERMINATION OF ELIGIBILITY		20. COM	PLIANCE WITH C		21. I. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :			A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  09/01/1985  (L24)  25. LTC EXTENSION DATE:	23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI	DATE	4. LTC AGREEMI ENDING DAT (L25)		VOLUNTARY 01-Merger, Cle 02-Dissatisfact 03-Risk of Inve	osure tion W/ Reimbursement oluntary Termination	INVOLUN' 05-Fail to M	L30) FARY eet Health/Safety eet Agreement
(L27)	A. Suspension of B. Rescind Susp		(L44) (L45)		04-Other Reaso	on for Withdrawal	07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C.	ARRIER NO.	(L31)	30. REMARK	CS.		
31. RO RECEIPT OF CMS-1539	(L32)	DETERMINATION C	DF APPROVAL DA	TE (L33)	DETERMI	NATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 14, 2015

Mr. Jack L'Heureux, Administrator St. Clare Living Community of Mora 110 North Seventh Street Mora, Minnesota 55051

RE: Project Number S5291024

Dear Mr. L'Heureux:

On June 25, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

### months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

### **DEPARTMENT CONTACT**

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338

Fax: (320)223-7348

### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 4, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

St Clare Living Community Of Mora July 14, 2015 Page 4

in your plan of correction.

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.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 25, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 December 25, 2015 (six months after the

St Clare Living Community Of Mora July 14, 2015 Page 5

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.

### INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 07/30/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	G	(3) DATE SURVEY COMPLETED
		245291	B. WING _		06/25/2015
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE  110 NORTH 7TH STREET  MORA, MN 55051	0.20.20
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMEN	ΓS	F 00	0	
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the optance. Because you are your signature is not required the first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 241 SS=E	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with	F 24	1	8/4/15
	manner and in an e	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observative review the facility farmorning routine for R1 and R13) who redressing. Furtherm a dignified dinning (R2) observed who eat.  Findings include: R6's quarterly Minir	tion, interview and document ailed to provide a dignified 4 of 19 residents (R6, R60, equired total assistance with more the facility did not provide experience for 1 of 4 residents required staff assistance to		F241 It is the policy of St. Clare Living Community to promote care for resid in a manner and in an environment th maintains or enhances each resident dignity and respect in full recognition his or her individuality. To assure continued compliance, the following p has been implemented: For R2, who is still in the facility, she been eating in the dining room since survey as she only eats in her room w she is not feeling well.	nat t¿s of olan has
ABORATOR	L Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**Electronically Signed** 

07/20/2015

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

	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL		SURVEY PLETED			
		245291	B. WING	<del></del>	06/2	25/2015
	PROVIDER OR SUPPLIER RE LIVING COMMUNI	TY OF MORA	1	STREET ADDRESS, CITY, STATE, ZIP CODE I10 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	impaired and need dressing and incondated 6/4/15, indicated 6/4/15, indicated for the day observation 6/25/15 observed to be asked of a pink sweatshir.  During interview 6/assistant (NA)-B ston R6 "at 6:30 a.m washed her up the stated she doesn't served at 10:30 a.m washed until 9:45 a.m.  R36's quarterly MD was severely cogniextensive assist wiincontinent of urine 6/19/15, indicated lone with dressing.  At 6/23/15, at 8:40 dressed for the day asleep. On 6/25/15 bed already dressed on, asleep.  During interview 6/stated R36 was we him in bed and left	ed total assist of one with tinent of urine. R6's care plan ated she required assist of one prefers to rise at 8:00 a.m.  6/23/15, at 8:35 a.m. R6 was in bed sleeping. During 5, at 8:39 a.m. R6 was eep in bed with her day clothes	F 241	The Policy and Procedure for mea assistance was reviewed by IDT Ji and remains appropriate. For all other residents who may be affected by this, audits will be done room trays to ensure proper proce followed to promote meal dignity. audits will be completed weekly for (4) weeks, monthly for three (3) meand randomly thereafter. For R6, R36, R1 and R13, who are residents of the facility, their care pand team sheets have been updat reflect their preferred wake time peresident Freedom Design interview family input. For all other residents who may be affected by this, audits will be done ensure residents are getting AM can a time they are able to choose. The residents who cannot speak will have cares done per their Freedom Desinterview or family input. These aus be completed weekly for four (4) we monthly for three (3) months and randomly thereafter. All staff will be educated on the Pla Correction on July 23, 2015. The Director of Nursing or Designed be responsible for compliance. Compliance Date: August 4, 2015	e with dure is These four onths e all still blans ed to er the vand or e to ares at e ave AM ign dits will reeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		06	/25/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 110 NORTH 7TH STREET MORA, MN 55051		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241	was severely cognassist of one with urine. R1's care pneeded assistance facility's Freedom sheet dated 6/20/1 start his morning buring observation observed in bed dunder the covers. was again in bed obutton down shirt,  R13's quarterly MI was severely cognotal assist with drurine. R13's care she needed total agrooming. R13's for Know Me sheet like to get up at 10 during observed to basleep with a hoye 6/25/15, at 8:35 a. the day in bed with During interview 6 stated, her shift stated, her shift stated and because we do not because we do not sheet days in because we do	S dated 5/28/15, indicated he litively impaired and needs total dressing and was incontinent of lan dated 5/28/15, indicated here of one with all dressing. R1's Design Getting To Know Me 4, indicated here would "like to be getting up at 10ish".  In 6/23/15, at 9:01 a.m. R1 was bressed for the day, asleep On 6/25/15 at 8:00 a.m. R1 dressed for the day in a tan sleeping.  DS dated 4/16/15, indicated she witively impaired and needed essing and was incontinent of plan dated 6/17/15, indicated lassist of one with dressing and acility Freedom Design Getting at 4/25/14 indicated she would	F 2	41		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245291	B. WING _		06	/25/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	,	, , , _ , _ , _ , _ , _ , _ , _
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	having them go be since they started includes brunch. dressed R6 at 6:3 because they were R13 up at 6:10 a.r for a bath and after placed her back in so she could sleep. During interview 6 services (SS)-A store be dressed and le to get up for the domain them to get up for the deaving them to sletter to get up for dress them when day.  A facility policy was residents and non R2's diagnoses, a Minimum Data Seincluded Alzheime	g residents while in bed, and ack to sleep for several years, the five meal plan which NA-B further stated she had 0 a.m. and R60 at 7:45 a.m. e both wet. NA-B stated she got m. because she was scheduled er that they dressed her and nto bed with her day clothes on o until brunch.  2/25/15, at 9:02 a.m. with social rated that residents should not fit to sleep before they are ready ay.  2/25/15, at 9:06 a.m.  RN)-A stated the staff should residents up, dressed and eep in bed until it was time for brunch. They should wait to they are ready to get up for the	F 24	1		
	extensive, one-pe activities of daily li During observatio nursing assistant morning cares for	ed, and further that she needed rson, physical assistance with ving, including eating.  n on 6/24/2015 at 7:47 a.m., (NA)-C completed routine R2, who was now dressed and el chair in her room. NA-C				

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		245291	B. WING _		06	/25/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 110 NORTH 7TH STREET MORA, MN 55051		720/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241	chair, then opened she had brought in small cup of ice wheel. NA-C, stand began feeding R2 NA-C gave R2 two then offered her wh?" NA-C then adrink?", as she sto another spoonful of R2's head moved were gently flailing approached from feeding her. NA-C feeding, offered R spoonful of yogurt after she began, Noreakfast.  In an interview on stated that R2 usubreakfast, and that Sand Sand Sand Sand Sand Sand Sand Sand	tioning device on R2's wheel d a small container of yogurt into the room, and placed a later on the dresser near R2's ling beside the wheel chair, yogurt with a plastic spoon. It is consecutive bites of yogurt, later, saying, "It's pretty cold, lasked R2 "Do you want another lood next to R2, again spooning of yogurt into R2's mouth. As from side to side, her arms g, NA-C walked around R2, then the other side, and continued C2, continuing to stand while late more water, and the last in At 7:51 a.m., four minutes NA-C was finished feeding R2	F 24	.1		
	room." NA-C ack earlier this mornin all the while stand During an intervie NA-D also said R2	aid, R2 often was fed breakfast "in her NA-C acknowledged that she fed R2 this morning in her room, and she fed R2 while standing up next to her.  an interview on 6/25/2015 at 10:25 a.m., also said R2 would have a light breakfast				
	some time to feed no' to feed a resid said feeding a res dignified."	ded, "you would want to take I [R2]." NA-D said, "It is a 'no ent while standing." NA-D also ident while standing was "Not 6/25/2015, registered nurse do not assist [feeding] people				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY MPLETED
		245291	B. WING		06/	/25/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	room, feeding ther appropriate."  In an interview on director or nursing provided to a resid their level to provided their level to provide their level their level to provide thei	e dining area, or in their own methods was "not"  6/25/2015 at 1:07 p.m., the (DON) said that assistance lent while eating "should be at de dignity for the resident."  eding Residents, undated, sks under "procedure", in a chair to feed the resident; e resident; and #17 Do not rush policy identified its purpose as	F 2	41		
F 309 SS=D	provide adequate in well-balanced mea 483.25 PROVIDE HIGHEST WELL E Each resident must provide the necess or maintain the high mental, and psych	CARE/SERVICES FOR	F3	09		8/4/15
	by: Based on observareview the facility fassess, and monit	ENT is not met as evidenced ation, interview, and document ailed to comprehensively or skin conditions for 1 of 6 viewed for skin concerns.		F309 It is the policy of St. Clare Living Community to provide or maintair highest practicable quality of care physical, mental and psychosocia well-being in accordance with the comprehensive assessment and	for I	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING			06/2	25/2015	
	PROVIDER OR SUPPLIE			110	REET ADDRESS, CITY, STATE, ZIP CODE D NORTH 7TH STREET DRA, MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	4/16/15 indicated impaired, required all cares and did in facility Observation and interventions vascular disease, with cares, and licinspection on bath R31's care plan dat risk for altered osteoarthrosis, pelumbago and dire with cares with licinspection on bath cares with licinspection on bath R31's care plan dat risk for altered osteoarthrosis, pelumbago and dire with cares with licinspection on the licinspection of the blad disfigured and the eschar present or knuckle and the eschar present or knuckle and the eschar present or knuckle and the mostiting up in her wishing up in he	inimum data set (MDS) dated she was severely cognitively dextensive assist of two staff for not ambulate. The 4/16/15 in Report identified risk factors which included; peripheral incontinence, skin check daily sensed nurse to do skin in day.  atted 4/29/15 indicated she was skin integrity related to eripheral vascular disease and cted staff to monitor skin daily ensed nurse inspecting skin and a skin assessment at least attion on 6/24/15, at 7:12 a.m., her right side in bed with her left nkets. R31's toes were ere was a small black area of in the third digit between the itail. At 7:51 a.m., R31 was heel chair wearing socks and	F3		care. To assure continued compliate following plan has been implement For R31, who still resides in the fact foot cradle was placed on the bed to prevent injury to her toe and her for was changed to diabetic socks with seams. Her care plan and teams were updated to reflect this. Her sk assessment remains current and appropriate. She remains on the word of the word	ed: cility, a co ot wear nout sheet in round n emains y ed by one n skin sure all		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		06	/25/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 110 NORTH 7TH STREET MORA, MN 55051	<b>.</b>	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	aware of the wour type of wound the R31 had. RN-A wa on R31's left foot.  Review of podiatri indicated R31 was for "painful nail de foot care." The no complained of pai and the "condition shoe gear which of further indicated Fand was "at risk for Review of the faci dated 4/22/2015 in Res [resident] right stable. No drainagh has another corn and remains intact noted. Res denies See wound assess measurements ar Review of the wee of Mora Wound R 6/17/15 identified The forms identified The forms identified ase, drainage, uncurrent treatment, any black area on identified or monit During an observant 2:40 p.m., of R5 practitioner (NP)-A	rade of the black area  as not aware of the black area  as notes dated 4/30/15, as being evaluated and treated aformities as well as generalized ates further indicated R31 and callous of gradual onset on is exacerbated by wearing causes pressure." The note R31 had vascular compromise or ulceration and/or infection."  lity Resident Progress Notes dentified, "Wound team rounds: at foot 2nd digit [toe] corn is age, redness or odor noted. Res this is at the tip of the same toe at. No drainage, redness or odor as pain, Will continue to monitor.  Sment flow sheet for and characteristics."  ekly St Clare Living Community eviews form from 4/22/15 to the "right foot 2nd digit corn". ed length, width, depth, wound andermining/tunneling, and There was no indication that R31's left foot had been ored by the facility.  A stated, "I don't think it looks as more like a blood blister."	F3	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING		06/	25/2015	
	NAME OF PROVIDER OR SUPPLIER  ST CLARE LIVING COMMUNITY OF MORA			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		_D BE	(X5) COMPLETION DATE	
F 309 F 315 SS=D	foot. NP further star wounds, "My suspice of ulcer." She further following her feet, I before."  During a subsequer p.m., RN-A stated to not wear shoes. She skin care treatment unaware R31 had at a Although R31 had a secondary wascular disease, a skin daily with cares nurse. There was not R31's left foot had be monitored by the fact a A policy on skin car requested but not requested but not reasonable assessment, the fact resident who enters indwelling catheter resident's clinical contact catheterization was who is incontinent of treatment and service function as possible function as possible and the resident would be refunction as possible function as possible function.	ted in regard to her (R31's) cion would be a vascular type er stated, "I have not been have not seen her toes  Int interview on 6/25/15, at 1:33 hat the resident (R31) does e stated R31 has no specific s for her feet and she was a black area on her left foot.  Tisk factors of peripheral and staff were to monitor her and weekly with a licensed to indication the black area on been identified or consistently cility.  The early prevention was eccived.  HETER, PREVENT UTI, ER  Tent's comprehensive cility must ensure that a staff acility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate fices to prevent urinary tract store as much normal bladder		315		8/4/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245291	B. WING		06/25	/2015
	NAME OF PROVIDER OR SUPPLIER  ST CLARE LIVING COMMUNITY OF MORA			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		
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F 315	by: Based on observareview, the facility assess a change if for 1 of 1 (R83) reincontinence statu.  Findings include: R83's admission 3/20/15, indicated intact, occasionally not on a toileting pindicated she need toileting and transity Assessment (CAA was occasionally in poor balance and The CAA further in hospital for possib care plan dated 3/continent of bladdoccasionally incon. R83's quarterly MI was now frequently needed extensive transfers, which we MDS dated 3/20/1 R83's facility Obseindicated she was alert and oriented, recognize the urg place to do so. Retransfers and need cares due to sling/identified to contin	ation, interview and document failed to comprehensively nurinary incontinence status viewed who had a change in s.  Minimum Data Set (MDS) dated she was moderately cognitively incontinent of urine and was program. The MDS also ded extensive assist with fers. R83's Care Area a) dated 3/25/15, indicated she incontinent of urine and has had a fractured left humerus. Indicated she was treated in the le urinary tract infection. R83's 30/15, indicated she is er and was noted to be tinent when first arrived.  DS dated 5/29/15, indicated she y incontinent of urine and assist with toileting and as a change from the previous	F 315	F315  It is the policy of St. Clare Living Community that based on the resid-comprehensive assessment, the far must ensure that a resident who en the facility without an indwelling catheterized unless the resident clinical condition demonstrates that catheterization was necessary; and resident who is incontinent of bladd receives appropriate treatment and services to prevent urinary tract inference as much normal black function as possible. To assure concompliance, following plan has bee implemented:  For R83, who still resides in the fact new Bowel and Bladder assessment completed on June 24, 2015. Care and team sheet are current and appropriate.  The Urinary Continence Policy and Procedure was created and reviews the IDT July 2015 and implemented For all other residents who may be affected by this, a new check list so of assessments for MDS; was devivith the bladder assessment includ and is being followed by the Nurse Managers completing the assessment includ and is being followed by the Nurse Managers completing the assessments is be done to ensure all appropriate assessments have been completed each MDS. These audits will be completed weekly for four (4) week monthly for three (3) months and randomly thereafter.  All staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff will be educated on the Plantary and the staff	cility Iters heter is tities a ler ections Ider Intinued	

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		245291	B. WING		06/2	25/2015	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 7TH STREET MORA, MN 55051	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 315	progress note date resident remains in continent of bowel with toileting and prequest assist with encourages fluids. and symptoms]".  Review of the facil Category Report fridentified R83 was 5/23/15 to 5/29/15 Bowel/Bladder ide times during this ti  During observation observed to be toil (NA)-A. R83's brie incontinent of urine incontinent of urine that R83 had an in incontinence and incontinence and ineed to reassessed.  During interview 6/ assistant (NA)-A state after view that R83 had an in incontinence and if the stay dry during the stay been reasses that have been reasses the same state of the stay of t	ed 5/29/15, identified the incontinent of urine and a Resident is assistance of one rericare. "Res [resident] able to toileting. Nsg [nursing] Monitor for urinary s/sx [signs ity Point of Care Bowel/Bladder from 3/14/15 to 3/20/13, only incontinent once. The facility Point of Care facility Point of Care ntified R83 was incontinent 21 me frame.  16/24/15, at 7:48 a.m. R83 was reted by nursing assistant from was wet, and she had been be at do the reassessments. She ing R83's record information, crease in her urinary from the are any changes they do her incontinence.  12/4/15, at 11:54 a.m. nursing tated R83 "is usually wet in the remind her to toilet she can day".	F 315	Correction on July 23, 2015. The Director of Nursing or Designor be responsible for compliance. Compliance Date: August 4, 2015  F315 Addendum 7/28/15 For all others who may be affect to IE: new admissions, and resident and new MDS; and provided appropriate treatment and services to achieve maintain as much normal urinary for as possible by  i Start new 3 day void  Complete a new bladder asse  Determine type of incontinency. Review bladder collection data individualized toileting patterns-accare plan and NAR sheet  Audit for timely toileting accordindividualized plan  Audits weekly for four weeks, for three months, then randomly the	by this are sid, e or function ssment e a for did to monthly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING		06/	25/2015	
	PROVIDER OR SUPPLIER RE LIVING COMMUNIT	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE  110 NORTH 7TH STREET  MORA, MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 315 F 323 SS=D	her voiding pattern placed on a toileting.  The facility policy Vi and Bladder Assess the purpose is to move and bladder in have a Bowel and Ecompleted upon adsignificant changes incontinent upon adtheir continence will bladder diary computed and Ecompleted upon adsignificant changes incontinent upon adtheir continence will bladder diary computed the ecomplete of the province of the facility must enenvironment remains is possible; and the facility must enenvironment remains as is possible; and the facility policy of the facility must enenvironment remains as is possible; and the facility policy of the facility must enenvironment remains as is possible; and the facility policy of the facility must enenvironment remains as is possible; and the facility policy of the facili	r stated she will also look at to see if she needs to be g plan.  Illa Health Care Center Bowel sment dated 8/06, indicated aintain or restore optimal functions. All residents will Bladder Assessment mission, quarterly, and with All residents who are mission or have a change in have a 3-day Bowel and leted.	F 3			8/4/15	
	by: Based on observat review, the facility fa safety devices to pr for 1 of 3 residents utilized anti-tip bars Findings include: R12's quarterly Min	ion, interview and document ailed to implement wheelchair event potential safety hazards (R12) in the sample who on their wheelchair.		F323 It is the policy of St. Clare Living C that the resident environment remafree of accident hazards as is possand each resident receives adequasupervision and assistive devices to prevent accidents. To assure conticompliance, the following plan has implemented:  For R12, the anti-tip bars were place.	ains as sible; ate so nued been		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		06/	25/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051			
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F 323	and diagnoses incobsessive-compul disorder. The MD totally dependent locomotion on and R12 was observed in her Tilt-N-Space and recline capab tilted back at an al R12 was moving hand forth causing while seated in the (devices used to put their wheelchair or wheelchair were ir purpose of the anti-buring observation was observed in his day room. He approximate 40 de intermittently and were jerking, whice minutes. The anti-be in the up position buring an interview nursing assistant (R12]'s anti-tipper am not sure why had registered nurse (familiar with the was needed her a loss of the six out."	sluding Alzheimer's disease, sive disorder, and anxiety S further indicated R12 was upon staff for transfers and d off the unit.  d on 6/23/15 at 3:39 p.m., sitting wheelchair (chair that has tilt ilities) in her room with her chair oproximate 50 degree angle. Her arms up and down and back forceful jerking movements e chair. The anti-tip bars prevent a patient from tipping wer backwards) on R12's in the up position, negating the citip bars.  In on 6/24/15 at 11:03 a.m., R12 her Tilt-N-Space wheelchair in a r chair was tilted an an egree angle. She was coughing when she coughed her arms helasted approximately 10 tip bars were again observed to	F 323	while the surveyor was present. plan and team sheet were update reflect the change.  A Wheel Chair and Specialized Chair Equipment use Policy and Procedure was created, reviewed and implemented July 2015.  For all other residents who may affected by this, audits are being wheel chair accessories that are for safety to ensure all measure appropriate and the least restrict These audits will be completed four (4) weeks, monthly for three months and randomly thereafter All staff will be educated on the Correction on July 23, 2015.  The Director of Nursing or Designer responsible for compliance. Compliance Date: August 4, 26	ted to Wheel ded by IDT be g done on e placed as are ctive. weekly for e (3) r. Plan of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING			06/2	25/2015
	PROVIDER OR SUPPLIER	TY OF MORA		11	TREET ADDRESS, CITY, STATE, ZIP CODE IO NORTH 7TH STREET IORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	NA-B stated, "I am anti-tipper bars on them." NA-B further moves around a lot When interviewed a stated, "The tilt bar not in the up position are not doing any goshould be in the dowill fix it right now" anti-tipper bars in the During interview on occupational therapanti-tippers should being used at all time. When interviewed assistive technolog Reliable Medical Schars were on whee mechanism. The Armad movements the bars should be in the ATP stated if [Finer chair, "the anti-position" and anyone around a lot when the anti-position" and anyone them.	on 6/24/15, at 11:32 a.m. not sure why [R12] has the her wheelchair. I never use er stated, "Some days [R12] tin her chair."  on 6/24/15, at 11:38 a.m. RN-A s should be turned around and on." RN-A further stated, "They good in the up position, they will proceeded to position the he correct, down position.  a 6/24/15, at 12:26 p.m. bist (OT-A) stated, "The be in the down position and mes."  on 6/25/15, at 2:37 p.m., the y professional, (ATP) from upply (RMS), stated anti-tip lichairs as a safety TP further stated, if someone at jerk the chair, "the anti-tip ne down position." In addition, at 12] has movements while in tippers should be in the down ne that has a tilt chair, which is always have the anti-tippers in	F3	23			
F 465 SS=D	from the facility, but 483.70(h)	device policy was requested t not provided.  AL/SANITARY/COMFORTABL	F 4	.65			8/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING _		06/3	25/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	<u>,                                    </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 465	sanitary, and comfresidents, staff and This REQUIREME by: Based on observa	rovide a safe, functional, fortable environment for	F 46	F465 It is the policy of St. Clare Living		
	(R5), whose rooms observed for clear shows annual Minim 4/17/2015, identific cognitively impaire included neurogen indwelling catheter 4/17/2015 indicate one with toileting, the assist of one with toileting the assist of one with allway immediate. During observation on 6/24/2015 at 7: present a strong, present a strong, present and bedding, on top of the bed.	for free for 1 of 3 residents on the north wing were aliness.  Turn Data Set (MDS), dated ed R5 was moderately, ed, had diagnoses which hic bladder, and had an r. R5's care plan, updated ed R5 needed the assistance of per request, and also required with clothing management.  Four of the facility on 6/22/2015 was a strong, lingering smell is room, as well as in the ely outside R5's room.  In of morning cares in R5's room of morning cares in R5's room of a.m., there again was bermeating smell of urine in odor was also present on R5's as well as from a blanket laying 6/24/2015 at 7:20 a.m., RN)-C said there was a smell of		Community to provide a safe, fur sanitary and comfortable enviror residents. Staff and the public. To continued compliance, following been implemented:  For the one room cited, a new mas placed on the bed; all perso blankets and clothing were laund. The resident is shower schedule changed from twice weekly to the weekly with bedding changes eashower day. The closet was cleasterilized. A Rubbermaid contain lid was obtained to store the cath supplies. The resident is person was steam cleaned. The resident longer uses the recliner and fam removed it from the room. The Housekeeping Daily Room (Policy and Procedure were creat reviewed by IDT and implemente 2015.  For all other residents who may affected by this, audits are being completed. These audits will be completed weekly for four (4) we monthly for three (3) months and randomly thereafter.  All staff will be educated on the Familia and the staff will be educated on the staff wi	ament for a assure plan has attress nal dered. was ree times chaned and ner with neter al recliner t no illy  Cleaning red, ed July  Dee reks,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY IPLETED
		245291	B. WING		06/	25/2015
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 465	came from [R5]'s p RN-C also stated F infections because R5 "was not a big, nursing assistants three times each sl collection devices w solution," and store  During an interview nursing assistant (I odor in R5's room, strong. NA-A also encouragement to the residents' room on resident bath da was not sure how o blankets were clear  During an interview family visitor (FV)-A R5's room many tir was thoroughly clea the facility "nearly o hallway next to the  In an interview on 6 housekeeper (HK)- of urine in [R5]'s ro rooms and bathroo and there was a so more thoroughly cle HK-A said there we R5's room, or the u each resident's roo dust, wipe down the	and thought the odor "possibly bersonal clothing or blankets." R5 was at risk for urinary tract of her catheter use, and that fluid drinker." RN-C said the drain R5's catheter bag "two to nift," and that the urine were "cleaned with vinegared in R5's closet.  You on 6/24/2015 at 7:27 a.m., NA)-A said there was urine and that R5's urine was often said R5 needed drink fluids. The bedding in as were changed "once weekly ays," and as needed. NA-A often residents' personal	F 465	Correction on July 23, 2015. The Director of Maintenance o will be responsible for compliar Compliance Date: August 4, 2	nce.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		06	/25/2015	
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP ( 110 NORTH 7TH STREET MORA, MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 465	Continued From pa	age 16	F 4	65			
		on 6/25/2015 at 8:27 a.m., distinct, lingering odor of urine adjacent hallway.					
	said "I do smell urii in R5's room. RN- was a problem with suspect a problem said, that R5's roor bedding changes, a beds and linens."	6/25/2015 at 8:29 a.m., RN-A ne, and have noticed the smell" A stated she did not think there in the collection devices, nor with R5's catheter. RN-A in needed "more frequent and a stronger cleaning of the RN-A also thought a more of R5's "personal laundry ankets," was in order.					
	had a strong urine provided more freq contents, or implen	nd staff were aware R5's room odor, the facility had not juent cleaning of the room or nented other techniques or decrease or eliminate the					
	Resident Leaves," direction for staff re expected after a re facility. The policy room cleaning, suc for resident rooms	orough Cleaning Room after revised 3/26/2013, included egarding what cleaning was sident is discharged from the did not address the day-to-day thas the frequency of cleaning and personal items, or o reduce and eliminate odors.					

F5291023

Printed: 06/24/2015 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245291

B. WING.

06/23/2015

NAME OF PROVIDER OR SUPPLIER

### ST CLARE LIVING COMMUNITY OF MORA

STREET ADDRESS, CITY, STATE, ZIP CODE

110 NORTH 7TH STREET

SICLA		) NORTH 7TH )RA, MN 5505		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION)	ID ORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	FIRE SAFETY			
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 5, 2013. At the time of this survey, St. Clare Living Community of Mora was found in substantial compliance with the requirements for participation Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.	.t		
	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 a is separated by 2 hour construction with a 90 minuted rated, self closing door. Another addition of Type V(111) construction opened to the west 2005, therefore the building was inspected as 2 buildings.	al pe e nd on in		
	The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facili has a licensed capacity of 65 beds and had a census of 45 at the time of the inspection.	ty		
	The requirement at 42 CFR Subpart 483.70(a) Met.	is		
LABORATO	 	SIGNATURE	TITLE	(X6) DATE

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

Printed: 06/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER STICLARE LIVING COMMUNITY OF MORA

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

245291

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 02 - VILLA HEALTH CARE CENTER

(X3) DATE SURVEY COMPLETED

06/23/2015

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

110 NORTH 7TH STREET

ST CLAF	RE LIVING COMMUNITY OF MORA		TH 7TH S MN 55051		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RI 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
K 000	INITIAL COMMENTS		K 000		
	FIRE SAFETY				
	Building #2				
	A Life Safety Code Survey was conducte Minnesota Department of Public Safety, 5 Fire Marshal Division, on September 5, 2 the time of this survey St. Clare Living Community of Mora Building #2, the 2008 addition, was in compliance with the required for participation in Medicare/Medicaid at Subpart 483.70(a). Life Safety from Fire, 200 edition of National Fire Protection As (NFPA) Standard 101, Life Safety Code (Chapter 18 New Health Care.	State 2013. At 5 uirements 42 CFR, and the sociation	ÿ		
	St. Clare Living Community of Mora (Bui is a one story building story building with basement The building was constructed in Type V (111) construction. The facility has complete automatic sprinkler system, wit detection in the corridors and spaces oper corridor, that is monitored for automatic f department notification. All resident room single station smoke detectors that transformers station. The facility has a license capacity of 65 and a census of 45 at the inspection.	no in 2005 as a h smoke en to the ire ns have mit to the			
-				350	
LABORATOR	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEN	ITATIVE'S SIGNA	ATURE	TITLE	(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted July 14, 2015

Mr. Jack L'Heureux, Administrator St. Clare Living Community of Mora 110 North Seventh Street Mora, Minnesota 55051

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5291024

Dear Mr. L'Heureux:

The above facility was surveyed on June 22, 2015 through June 25, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

St Clare Living Community Of Mora July 14, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 07/30/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00814 06/25/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET ST CLARE LIVING COMMUNITY OF MORA MORA, MN 55051 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*ATTENTION\*\*\*\*\* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a

**INITIAL COMMENTS:** 

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**Electronically Signed** 

(X6) DATE 07/20/15 Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00814	B. WING		06/2	5/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST CLA	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, M	TH 7TH STRE N 55051	EET .			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 000	you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the dat Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To assigned to Minnesota Department be state in the State Licensing federal software. To state in the State in the statement evidence by." Following which are in after the statement evidence by." Following the Suggested Time period for Country Provider's PLASE DISREGATOURTH COLUMNITE OF The DESTATE COLUMNITE TO FEDERATE TO FED	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  2015 surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting correction Orders using ag numbers have been cota state statutes/rules for umber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE	2 000				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/2	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
ST CLARE LIVING COMMUNITY OF MORA  110 NORTH 7TH STREET  MORA, MN 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) COMPLETE DATE
2 000	Continued From page 2		2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General  Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.		2 830			7/20/15
	by: Based on observative review the facility facility facility facility facility facility facility facility facility facility.	ent is not met as evidenced ion, interview, and document alled to comprehensively or skin conditions for 1 of 6 iewed for skin concerns.		Corrected		
	Findings include:					
	4/16/15 indicated s impaired, required all cares and did no facility Observation and interventions w	nimum data set (MDS) dated he was severely cognitively extensive assist of two staff for of ambulate. The 4/16/15 Report identified risk factors which included; peripheral acontinence, skin check daily				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
711127 127111	or connection	IBERTII IOMION	TOMBET II.	A. BUILDING:		00.0		
		00814		B. WING		06/2	25/2015	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST CLAF	ST CLARE LIVING COMMUNITY OF MORA  110 NORTH 7TH STREET  MORA, MN 55051							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 830	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		2 830					
	indicated R31 was for "painful nail defo							

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 4 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/	25/2015	
	PROVIDER OR SUPPLIER	TY OF MORA 110 NOR	DDRESS, CITY, ST TH 7TH STRE MN 55051				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
2 830	foot care." The note complained of pain and the "condition shoe gear which ca further indicated R3 and was "at risk for Review of the facilit dated 4/22/2015 ide Res [resident] right stable. No drainage has another corn thand remains intact. noted. Res denies particularly See wound assess measurements and Review of the week of Mora Wound Re 6/17/15 identified thase, drainage, uncurrent treatment. any black area on Fidentified or monito.  During an observat at 2:40 p.m., of R3 practitioner (NP)-A like pressure, looks The NP began tout and R31 was unable foot. NP further star wounds, "My suspit of ulcer." She further following her feet, I before."	es further indicated R31 ful callous of gradual onset in is exacerbated by wearing cuses pressure." The note is 1 had vascular compromise ulceration and/or infection."  Ty Resident Progress Notes entified, "Wound team rounds: foot 2nd digit [toe] corn is expressed as a the tip of the same toe No drainage, redness or odor noted. Results is at the tip of the same toe No drainage, redness or odor pain, Will continue to monitor. The characteristics."  Ty St Clare Living Community wiews form from 4/22/15 to the "right foot 2nd digit corn". It length, width, depth, wound dermining/tunneling, and There was no indication that R31's left foot had been					

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 5 of 24

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/25/2015	
NAME OF				27ATE 7ID 00DE	00/2	3/2013
	PROVIDER OR SUPPLIER	110 NOR	TH 7TH STRI	STATE, ZIP CODE <b>FFT</b>		
ST CLAF	RE LIVING COMMUNI	TY OF MORA MORA, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 5	2 830			
	skin care treatment unaware R31 had a Although R31 had a vascular disease, a skin daily with care nurse. There was r	he stated R31 has no specific ts for her feet and she was a black area on her left foot.  risk factors of peripheral and staff were to monitor her is and weekly with a licensed to indication the black area on been identified or consistently acility.				
	A policy on skin car requested but not r	re and prevention was eceived.				
	Based on observation, interview and document review, the facility failed to implement wheelchair safety devices to prevent potential safety hazards for 1 of 3 residents (R12) in the sample who utilized anti-tip bars on their wheelchair.					
	Findings include:					
	5/28/15, indicated s and diagnoses incl obsessive-compuls disorder. The MDS	simum Data Set (MDS), dated severe cognitive impairment uding Alzheimer's disease, sive disorder, and anxiety of further indicated R12 was pon staff for transfers and off the unit.				
	in her Tilt-N-Space and recline capabil tilted back at an ap R12 was moving he and forth causing for while seated in the (devices used to protheir wheelchair over	on 6/23/15 at 3:39 p.m., sitting wheelchair (chair that has tilt ities) in her room with her chair proximate 50 degree angle. er arms up and down and back orceful jerking movements chair. The anti-tip bars revent a patient from tipping er backwards) on R12's the up position, negating the				

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 6 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/	25/2015
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY,			
ST CLAF	RE LIVING COMMUNIT	TY OF MORA	RTH 7TH STRI MN 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	purpose of the antit  During observation was observed in he the day room. Her approximate 40 deg intermittently and w were jerking, which minutes. The anti-ti be in the up position  During an interview nursing assistant (N [R12]'s anti-tipper b am not sure why he R12 "does not sit co out."  When interviewed or registered nurse (R familiar with the wh R12 needed her an RN-B then said, "I w During an interview NA-B stated, "I am anti-tipper bars on h them." NA-B furthe moves around a lot  When interviewed of stated, "The tilt bars not in the up position are not doing any g should be in the dow will fix it right now" a anti-tipper bars in th  During interview on	tip bars.  on 6/24/15 at 11:03 a.m., R1 ar Tilt-N-Space wheelchair in chair was tilted an an gree angle. She was coughing then she coughed her arms alasted approximately 10 ip bars were again observed in.  on 6/24/15, at 11:16 a.m. NA)-E stated, "I would assume are suppose to be downers are up." NA-E also stated ontently, she often screams on 6/24/15, at 11:23 a.m. and sars and was not aware atti-tipper bars up or down. will have to look into this."  on 6/24/15, at 11:32 a.m. not sure why [R12] has the her wheelchair. I never use ar stated, "Some days [R12] in her chair."  on 6/24/15, at 11:38 a.m. RN is should be turned around aron." RN-A further stated, "The lood in the up position, they were position." RN-A stated, "I and proceeded to position the proceeded to position the proceeded to position." in 6/24/15, at 12:26 p.m.	e , I d, if			
		pist (OT-A) stated, "The				

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 7 of 24

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/2	25/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, \$ <b>TH 7TH STRI</b>	STATE, ZIP CODE			
ST CLAF	RE LIVING COMMUNI	TY OF MORA MORA, MI		-L 1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	anti-tippers should being used at all ting. When interviewed assistive technolog Reliable Medical States were on whee mechanism. The Almondar movements the bars should be in the ATP stated if [Refer chair, "the antiposition" and anyoutilted back, "should the down position."  A wheelchair safety from the facility, but SUGGESTED MET The director of nursitaff and perform a is receiving appropriate and staff and perform a in the	be in the down position and nes."  on 6/25/15, at 2:37 p.m., the y professional, (ATP) from upply (RMS), stated anti-tip lchairs as a safety TP further stated, if someone at jerk the chair, "the anti-tip ne down position." In addition, at 2] has movements while in tippers should be in the down ne that has a tilt chair, which is always have the anti-tippers in device policy was requested to not provided.  THOD OF CORRECTION: sing or designee could train all udits to ensure each resident riate nursing care and	2 830				
	In addition, the dire could inservice staf devices, proper us audit for complianc	oressure skin related issues. ctor of nursing or designee if regarding wheelchair safety e of safety devices, and then e.  R CORRECTION: Twenty One					
2 840	(21) days.  MN Rule 4658.052	0 Subp. 2 B Adequate and	2 840			7/20/15	
<b></b>	Proper Nursing Car	re; Clean skin	<b>_</b>			., _ 5, 10	
		or determining adequate and criteria for determining					

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 8 of 24 B20W11

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00814	B. WING		06/2	5/2015
	PROVIDER OR SUPPLIER	110 NOR	TH 7TH STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	B. Clean skin a odors. A bathing place resident's plan of carcondition requires to must be given a condition resident every two hours, and following each episor [144A.04 Subd. 11 Notwithstanding Mid 4658.0520, an inconchecked according written in the resident attending physician interval longer than if competent, or a far appointed conservation agent of a resident in writing to waive production to waive promptly each time. Clean linens or clot promptly each time. Perineal care including the perineal area. It is keep the bed dry comfort. Special at skin to prevent irritatives of protectors completely covered contact with the resident in the resident in the perineal area. It is keep the bed dry comfort. Special at skin to prevent irritatives of protectors completely covered contact with the resident in the perineal care includes the perineal area. It is keep the bed dry comfort. Special at skin to prevent irritatives of protectors completely covered contact with the resident in the perineal care includes the perineal area. It is the perineal area. It is the perineal area and the perineal area area. It is the perineal area area area and the perineal area area. It is the perineal area area area and the perineal area area. It is the perineal area area area area. It is the perineal area area area area. It is the perineal area area area area area area area. It is the perineal area area area area area area area a	er care include:  and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every often as indicated. An a must be checked at least ad must receive perineal care ode of incontinence.  Incontinent residents. Incontinent residents. Incontinent residents and specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident, amily member or legally ator, guardian, or health care who is not competent, agrees onlysician involvement in erval, and this waiver is resident's care plan. I hing must be provided the bed or clothing is soiled. The bed or clothing is soiled and for the resident's tention must be given to the ation. Rubber, plastic, or other must be kept clean, be and not come in direct ident. Soiled linen and moved immediately from	2 840			

6899

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/25/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NOR' MORA, M	TH 7TH STR N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	Continued From pa	age 9	2 840			
	by: Based on observat review, the facility f assess a change ir for 1 of 1 (R83) rev incontinence status	ent is not met as evidenced ion, interview and document ailed to comprehensively urinary incontinence status iewed who had a change in s.		Corrected		
	Findings include:					
	R83's admission Minimum Data Set (MDS) dated 3/20/15, indicated she was moderately cognitively intact, occasionally incontinent of urine and was not on a toileting program. The MDS also indicated she needed extensive assist with toileting and transfers. R83's Care Area Assessment (CAA) dated 3/25/15, indicated she was occasionally incontinent of urine and has poor balance and had a fractured left humerus. The CAA further indicated she was treated in the hospital for possible urinary tract infection. R83's care plan dated 3/30/15, indicated she is continent of bladder and was noted to be occasionally incontinent when first arrived.					
	was now frequently needed extensive a	PS dated 5/29/15, indicated she incontinent of urine and assist with toileting and as a change from the previous 5.				
	indicated she was a alert and oriented, recognize the urge place to do so. Re transfers and need	rvation Report dated 3/14/15, currently continent of bladder, able to verbalize and to urinate and appropriate quires assistance of two for s assistance with toileting cast on left arm. The report				

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 10 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/	25/2015
	PROVIDER OR SUPPLIER	TY OF MORA 110 NOR	DDRESS, CITY, S' TH 7TH STRE MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 840	they would initiate the progress note dated resident remains in continent of bowel. With toileting and perequest assist with encourages fluids, and symptoms]".  Review of the facility Category Report from identified R83 was 5/23/15 to 5/29/15, Bowel/Bladder identimes during this times during this times during this time. During observation observed to be toiled (NA)-A. R83's brief incontinent of urine. During interview 6/2 practical nurse (LPI MDS's but does not stated after reviewing that R83 had an incontinence and if need to reassessed. During interview 6/2 assistant (NA)-A stated assessments and juincontinence status incontinence status incontinence status.	e to assist with toileting and he the plan of care. A d 5/29/15, identified the continent of urine and Resident is assistance of one ericare. "Res [resident] able to toileting. Nsg [nursing] Monitor for urinary s/sx [signs by Point of Care Bowel/Bladder om 3/14/15 to 3/20/13, only incontinent once. The facility Point of Care tified R83 was incontinent 21 ne frame.  6/24/15, at 7:48 a.m. R83 was eted by nursing assistant was wet, and she had been was wet, and she had been at do the reassessments. She in g R83's record information, crease in her urinary there are any changes they her incontinence.  24/15, at 11:54 a.m. nursing ated R83 "is usually wet in the emind her to toilet she can day".				

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 11 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		00814	B. WING		06/25/2015	
	PROVIDER OR SUPPLIER	110 NOR	TH 7TH STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	when her quarterly 2015. RN-A furthe her voiding pattern placed on a toileting. The facility policy V and Bladder Assess the purpose is to m bowel and bladder have a Bowel and E completed upon ad significant changes incontinent upon act their continence will Bladder diary comp	MDS was completed in May r stated she will also look at to see if she needs to be g plan.  illa Health Care Center Bowel sment dated 8/06, indicated aintain or restore optimal functions. All residents will Bladder Assessment mission, quarterly, and with . All residents who are Imission or have a change in I have a 3-day Bowel and eleted.  THOD OF CORRECTION: The	2 840			
	policies and proced staff, assess the sy residents who have incontinence to be	and/or designee could review lures, revise as needed, train stem, and evaluate to assure a change in urinary reassessed.  R CORRECTION: Twenty-one				
21426	Prevention And Cor (a) A nursing home maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta	A.04 Subd. 3 Tuberculosis ntrol e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis	21426			7/20/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		00814	B. WING		06/2	5/2015
_	PROVIDER OR SUPPLIER	110 NOR	TH 7TH STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	unpaid employees, residents, and volui Health shall provide regarding implemen	n that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.	21426			
	This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a tuberculosis (TB) symptom screening was completed upon admission and failed to record results in millimeters (mm) of induration for 5 of 5 residents (R41, R50, R8, R10 and R11) reviewed for TB compliance during the survey.			Corrected		
	Facility Tuberculosi Worksheet for heal the Minnesota Depa reviewed 4/27/15), be performing base of admission, which	lity's, assessment, entitled: s (TB) Risk Assessment th Care Settings Licensed by artment of Health (last identified that the facility would line TB screening at the time in the facility utilized the nnesota Department of				
	In the review of 5 of the following was no	f 5 currently residing residents oted:				
	R41 had a the First	Step TST (tuberculin skin test				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00814	B. WING		06/2	5/2015
NAME OF PROVIDER OR SUPPLIER  ST CLARE LIVING COMMUNITY O	110 NORT	H 7TH STRE	ETATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BY BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
"neg" (negative) only do Step TST was given on 11/23/14, also document lacked any evidence of screen being performed.  R50 had a the First Step and read on 6/26/14 with documented. The Secon 3/26/15 and read on 3/2 "neg". R50's chart lacked tuberculosis symptom so R8 had a the First Step read on 6/26/14 with "ned documented. The Secon 11/21/14 and read on 11 as "neg". R8's chart lacked tuberculosis symptom so R10 had a chest x-ray previous positive reaction evidence of a tuberculosis performed.  R11 had a the First Step and read on 9/31/15 with documented. The Secon 6/8/15 and read on 6/11 "neg". R11's chart lacked tuberculosis symptom so Four of the five resident TSTs were not document but rather "neg."  During interview on 6/26	and read on 8/21/14 with boumented. The Second 11/21/14 and read on the as "neg". R41's chart a tuberculosis symptom of the as "neg" (negative) only and Step TST was given on 28/15, also documented as coreen being performed as coreen being performed. TST given on 5/29/15 ch "neg" (negative) only and Step TST was given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed. TST given on 1/15, also documented as coreen being performed.				

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 14 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X2) A. BUILDING:			
		00814	B. WING	B. WING		25/2015
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE	•	
ST CLAR	RE LIVING COMMUNIT	TY OF MORA	RTH 7TH STR MN 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	not are we perform well." The A-DON for the expectation of the expectation of the expectation of the expectation of the expectation control numbers and the edge of the edge o	results for resident correctly, ing symptom screening as urther stated that this would be facility.  on 6/26/15 at 1:20 p.m., the rese (RN) -N stated that she locumenting "neg" was and did not know symptom dents were not being  THOD OF CORRECTION: The and/or designee could review and procedures and educate consible for the provision of 1	ie B			
21695	MN Rule 4658.1415 Housekeeping, Ope Subp. 4. Houseke provide housekeepi necessary to mainta comfortable interior ceilings, registers, f and furnishings.  This MN Requireme by: Based on observati review, the facility fa	5 Subp. 4 Plant eration, & Maintenance eping. A nursing home musting and maintenance service ain a clean, orderly, and r, including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on, interview and document ailed to ensure resident room or free for 1 of 3 residents	S	Corrected		7/20/15

6899

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/25/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST CLARE LIVING COMMUNITY OF MORA 110 NOR MORA, N			'H 7TH STRE N 55051	EET		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 15	21695			
	(R5), whose rooms observed for cleanl	on the north wing were iness.				
	Findings include:					
	4/17/2015, identifie cognitively impaired included neurogeni indwelling catheter. 4/17/2015 indicated one with toileting, p the assist of one with toileting the assist of one will buring the initial totat 2:01 p.m., there of urine inside R5's hallway immediated buring observation on 6/24/2015 at 7:0 present a strong, present a strong, present a strong.	um Data Set (MDS), dated d R5 was moderately, d, had diagnoses which c bladder, and had an R5's care plan, updated d R5 needed the assistance of er request, and also required th clothing management.  The facility on 6/22/2015 was a strong, lingering smell room, as well as in the y outside R5's room.  Of morning cares in R5's room of a.m., there again was be ermeating smell of urine in odor was also present on R5's s well as from a blanket laying				
	registered nurse (Rurine in R5's room, came from [R5]'s p RN-C also stated Finfections because R5 "was not a big, nursing assistants of three times each should collection devices visolution," and store During an interview	6/24/2015 at 7:20 a.m., and thought the odor "possibly ersonal clothing or blankets." as was at risk for urinary tract of her catheter use, and that fluid drinker." RN-C said the drain R5's catheter bag "two to hift," and that the urine were "cleaned with vinegar d in R5's closet.				

6899

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00814		B. WING		06/25/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST CLARE LIVING COMMUNITY OF MORA  110 NOR MORA, N			'H 7TH STRE N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ige 16	21695			
	strong. NA-A also encouragement to the residents' room on resident bath da	drink fluids. The bedding in s were changed "once weekly lys," and as needed. NA-A often residents' personal				
	During an interview on 6/24/2015 at 11:32 a.m., family visitor (FV)-A stated she has walked past R5's room many times, and wondered if the room was thoroughly cleaned. The FV-A said she visits the facility "nearly daily," and that R5's room, and hallway next to the room, "does smell."					
	In an interview on 6/24/2015 at 12:15 p.m., housekeeper (HK)-A said there was "some smell" of urine in [R5]'s room. HK-A stated resident rooms and bathrooms were cleaned every day, and there was a schedule for each room to be more thoroughly cleaned on a routine basis. HK-A said there were "no special treatment" for R5's room, or the urine odor. On a daily basis in each resident's room, "the garbage goes out, we dust, wipe down the sink, stool, soap and towel dispenser, put chemical on it, then the floors get wiped down."					
		on 6/25/2015 at 8:27 a.m., distinct, lingering odor of urine adjacent hallway.				
	said "I do smell urir in R5's room. RN-7 was a problem with suspect a problem said, that R5's room bedding changes, a	6/25/2015 at 8:29 a.m., RN-A ne, and have noticed the smell" A stated she did not think there is the collection devices, nor with R5's catheter. RN-A in needed "more frequent and a stronger cleaning of the RN-A also thought a more				

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 17 of 24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING 06/		06/2	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	H 7TH STRE N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 17	21695			
		of R5's "personal laundry nkets," was in order.				
	Although visitors and staff were aware R5's room had a strong urine odor, the facility had not provided more frequent cleaning of the room or contents, or implemented other techniques or procedures to help decrease or eliminate the urine odor.					
	Resident Leaves," direction for staff re expected after a refacility. The policy room cleaning, suc for resident rooms	brough Cleaning Room after revised 3/26/2013, included agarding what cleaning was sident is discharged from the did not address the day-to-day has the frequency of cleaning and personal items, or o reduce and eliminate odors.				
	The administrator of review, and/or revise ensure resident root clean and free of uprovided to all approand procedures and	THOD OF CORRECTION: or designee could develop, se policies and procedures to oms and bathrooms are kept rine odors. Education could be opriate staff on the policies d develop a monitoring ongoing compliance.				
	TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			7/20/15
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00814	B. WING		06/2	5/2015
			TH 7TH STR	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 18	21805			
	by: Based on observation review the facility farmorning routine for R1 and R13) who reduces in a dignified dinning (R2) observed who eat.  Findings include: R6's quarterly Minimed (R2) indicated she impaired and needed dressing and inconducted 6/4/15, indicated she impaired and needed dressing and inconducted 6/4/15, indicated she impaired and needed dressing and puring observation dressed for the day observation 6/25/15 observed to be asle of a pink sweatshirt.  During interview 6/2 assistant (NA)-B stated she doesn't desired she desired she doesn't desired she d	ent is not met as evidenced on, interview and document alled to provide a dignified 4 of 19 residents (R6, R60, equired total assistance with nore the facility did not provide experience for 1 of 4 residents required staff assistance to mum Data Set (MDS) dated e was severely cognitively ed total assist of one with tinent of urine. R6's care plan ated she required assist of one orefers to rise at 8:00 a.m.  6/23/15, at 8:35 a.m. R6 was a in bed sleeping. During 5, at 8:39 a.m. R6 was a in bed with her day clothes a con.  25/15, at 8:43 a.m. nursing ated that when she checked and her pad was wet so I just a and dressed her". NA-B then eat until brunch which is n. so we don't get her out of		Corrected		
	was severely cogni-	S dated 6/4/15, indicated he tively impaired, needed h dressing and was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00814		B. WING		06/25/2015	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	3/2013
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	H 7TH STRI N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21805	6/19/15, indicated hone with dressing.  At 6/23/15, at 8:40 dressed for the day asleep. On 6/25/15 bed already dresse on, asleep.  During interview 6/2 stated R60 was we him in bed and left get him up for bruna.m.  R1's quarterly MDS was severely cognitassist of one with durine. R1's care planeded assistance facility's Freedom Esheet dated 6/20/14 start his morning by During observation observed in bed dreunder the covers. Owas again in bed disbutton down shirt, see R13's quarterly MD was severely cognitated assist with dreurine. R13's care planeded total as grooming. R13's fare grooming.	R60's care plan dated are needed extensive assist of a.m. R60 was observed in bed with sheets pulled over him, at 8:43 a.m. he was again in d for the day with a blue shirt 25/15, at 8:45 a.m. NA-B twith urine so she dressed him to sleep until she would ch that was served at 10:30 dated 5/28/15, indicated he tively impaired and needs total ressing and was incontinent of an dated 5/28/15, indicated he of one with all dressing. R1's Design Getting To Know Me 4, indicated he would "like to y getting up at 10ish".  6/23/15, at 9:01 a.m. R1 was essed for the day, asleep on 6/25/15 at 8:00 a.m. R1 ressed for the day in a tan	21805			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 20 of 24 B20W11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			E SURVEY PLETED	
		00814	B. WING		06/	25/2015
ST CLARE LIVING COMMUNITY OF MORA 110 NORT			ADDRESS, CITY, S RTH 7TH STRE MN 55051	*		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21805	like to get up at 10:  During observation was observed to be asleep with a hoyer 6/25/15, at 8:35 a.m. the day in bed with  During interview 6/2 stated, her shift stated, her shift stated oes her first round urine she will dress awake. They can go because we do not brunch until 10:30 a had been dressing having them go bac since they started the includes brunch. Not dressed R6 at 6:30 because they were R13 up at 6:10 a.m. for a bath and after placed her back into so she could sleep.  During interview 6/2 services (SS)-A state be dressed and left to get up for the day.  During interview on registered nurse (R) not be getting the releaving them to sleet them to get up for the day.	6/25/15, at 10:02 a.m. R13 and described and she was again dressed for a yellow shirt on, asleep.  25/15, at 8:43 a.m. NA-B and when she was a since they are possible to sleep if they want, get the residents up for a.m. NA-B then stated they residents while in bed, and a.m. and R60 at 7:45 a.m. both wet. NA-B stated she pad a.m. and R60 at 7:45 a.m. both wet. NA-B stated she go. because she was scheduled that they dressed her and a bed with her day clothes on until brunch.	ot d			

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 21 of 24

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00814	B. WING		06/	25/2015
			DDRESS, CITY, S' RTH 7TH STRE MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21805	residents and none R2's diagnoses, as Minimum Data Set included Alzheimer The MDS also indic cognitively impaired extensive, one-pers activities of daily liv  During observation nursing assistant (N morning cares for F seated in the whee rearranged a positic chair, then opened she had brought int small cup of ice wa bed. NA-C, standir began feeding R2 y NA-C gave R2 two then offered her wa uh?" NA-C then as drink?", as she stod another spoonful of R2's head moved fi were gently flailing, approached from th feeding her. NA-C, feeding, offered R2 spoonful of yogurt. after she began, Na breakfast.  In an interview on 6 stated that R2 usua breakfast, and that also said, R2 often room." NA-C acknown."		1			

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 22 of 24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED	
		00814	B. WING	WING		5/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	'H 7TH STRE N 55051	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21805	NA-D also said R2 her room, and adde some time to feed [no' to feed a reside said feeding a reside dignified."  In an interview on 6 (RN)-A said, "We destanding." Further, resident was in the room, feeding them appropriate."  In an interview on 6 director or nursing provided to a reside their level to provide their level to provide their level to provide a numerous tast including: #12 Sit is #15 do not rush the the resident. The provide adequate most adequate most and supprovide adequate most supprovide adequate most supprovide adequate most supprovide staff dining services and	ng up next to her.  If on 6/25/2015 at 10:25 a.m., would have a light breakfast in ed, "you would want to take R2]." NA-D said, "It is a 'no nt while standing." NA-D also dent while standing was "Not solvent while standing was "Not RN-A stated, regardless if a dining area, or in their own while standing was "not while standing was "not solvent while eating "should be at e dignity for the resident."  The eding Residents, undated, sks under "procedure", or a chair to feed the resident; are resident; and #17 Do not rush solicy identified its purpose as who have difficulty eating will utrition and attractive,	21805	DEFICIENCY)			

Minnesota Department of Health

STATE FORM B20W11 If continuation sheet 23 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(X3) DATE COMP	X3) DATE SURVEY COMPLETED	
	00814		B. WING		06/25/2015		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	5/2015	
	RE LIVING COMMUNI	110 NORT	H 7TH STRI				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21805	Continued From pa	ge 23	21805				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One					

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