MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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)
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DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: B20W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00814

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245291**

2.STATE VENDOR OR MEDICAID NO.
(L2) **064628000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST CLARE LIVING COMMUNITY OF MORA**
(L4) **110 NORTH 7TH STREET**
(L5) **MORA, MN** (L6) **55051**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2011**

6. DATE OF SURVEY **08/10/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**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 AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 08/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 08/12/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/01/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/07/2015
(L33)

DETERMINATION APPROVAL

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245291	A. Building B. Wing	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
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/04/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/04/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/04/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/04/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/04/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	08/12/2015	10562	08/10/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/25/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: B20W

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(L1) **245291**

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(L2) **064628000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST CLARE LIVING COMMUNITY OF MORA**
(L4) **110 NORTH 7TH STREET**
(L5) **MORA, MN** (L6) **55051**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2011**

6. DATE OF SURVEY **06/25/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**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)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mardelle Trettel, HFE NE II 07/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/04/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
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20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
09/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

Remedies - 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

Informal Dispute Resolution - 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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified morning routine for 4 of 19 residents (R6, R60, R1 and R13) who required total assistance with dressing. Furthermore the facility did not provide a dignified dinning experience for 1 of 4 residents (R2) observed who required staff assistance to eat. Findings include: R6's quarterly Minimum Data Set (MDS) dated 6/4/15 indicated she was severely cognitively	F 241	F241 It is the policy of St. Clare Living Community to promote care for residents in a manner and in an environment that maintains or enhances each resident¿s dignity and respect in full recognition of his or her individuality. To assure continued compliance, the following plan has been implemented: For R2, who is still in the facility, she has been eating in the dining room since survey as she only eats in her room when she is not feeling well.	8/4/15

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

Electronically Signed | 07/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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) COMPLETION DATE
F 241	Continued From page 1 impaired and needed total assist of one with dressing and incontinent of urine. R6's care plan dated 6/4/15, indicated she required assist of one with dressing and prefers to rise at 8:00 a.m. During observation 6/23/15, at 8:35 a.m. R6 was dressed for the day in bed sleeping. During observation 6/25/15, at 8:39 a.m. R6 was observed to be asleep in bed with her day clothes of a pink sweatshirt on. During interview 6/25/15, at 8:43 a.m. nursing assistant (NA)-B stated that when she checked on R6 "at 6:30 a.m. and her pad was wet so I just washed her up then and dressed her". NA-B then stated she doesn't eat until brunch which is served at 10:30 a.m. so we don't get her out of bed until 9:45 a.m. R36's quarterly MDS dated 6/4/15, indicated he was severely cognitively impaired, needed extensive assist with dressing and was incontinent of urine. R60's care plan dated 6/19/15, indicated he needed extensive assist of one with dressing. At 6/23/15, at 8:40 a.m. R36 was observed in bed dressed for the day with sheets pulled over him, asleep. On 6/25/15 at 8:43 a.m. he was again in bed already dressed for the day with a blue shirt on, asleep. During interview 6/25/15, at 8:45 a.m. NA-B stated R36 was wet with urine so she dressed him in bed and left him to sleep until she would get him up for brunch that was served at 10:30 a.m.	F 241	The Policy and Procedure for meal assistance was reviewed by IDT July 2015 and remains appropriate. For all other residents who may be affected by this, audits will be done with room trays to ensure proper procedure is followed to promote meal dignity. These audits will be completed weekly for four (4) weeks, monthly for three (3) months and randomly thereafter. For R6, R36, R1 and R13, who are all still residents of the facility, their care plans and team sheets have been updated to reflect their preferred wake time per the resident Freedom Design interview and or family input. For all other residents who may be affected by this, audits will be done to ensure residents are getting AM cares at a time they are able to choose. The residents who cannot speak will have AM cares done per their Freedom Design interview or family input. These audits will be completed weekly for four (4) weeks, monthly for three (3) months and randomly thereafter. All staff will be educated on the Plan of Correction on July 23, 2015. The Director of Nursing or Designee will be responsible for compliance. Compliance Date: August 4, 2015	

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F 241	Continued From page 2 R1's quarterly MDS dated 5/28/15, indicated he was severely cognitively impaired and needs total assist of one with dressing and was incontinent of urine. R1's care plan dated 5/28/15, indicated he needed assistance of one with all dressing. R1's facility's Freedom Design Getting To Know Me sheet dated 6/20/14, indicated he would "like to start his morning by getting up at 10ish". During observation 6/23/15, at 9:01 a.m. R1 was observed in bed dressed for the day, asleep under the covers. On 6/25/15 at 8:00 a.m. R1 was again in bed dressed for the day in a tan button down shirt, sleeping. R13's quarterly MDS dated 4/16/15, indicated she was severely cognitively impaired and needed total assist with dressing and was incontinent of urine. R13's care plan dated 6/17/15, indicated she needed total assist of one with dressing and grooming. R13's facility Freedom Design Getting To Know Me sheet 4/25/14 indicated she would like to get up at 10:00 a.m. During observation 6/25/15, at 10:02 a.m. R13 was observed to be dressed in bed for the day asleep with a hoyer lift sheet under her. On 6/25/15, at 8:35 a.m. R13 was again dressed for the day in bed with a yellow shirt on, asleep. During interview 6/25/15, at 8:43 a.m. NA-B stated, her shift starts at 6:00 a.m. and when she does her first rounds if a resident is wet from urine she will dress them in bed since they are awake. They can go back to sleep if they want, because we do not get the residents up for brunch until 10:30 a.m. NA-B then stated they	F 241		

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had been dressing residents while in bed, and having them go back to sleep for several years, since they started the five meal plan which includes brunch. NA-B further stated she had dressed R6 at 6:30 a.m. and R60 at 7:45 a.m. because they were both wet. NA-B stated she got R13 up at 6:10 a.m. because she was scheduled for a bath and after that they dressed her and placed her back into bed with her day clothes on so she could sleep until brunch.

During interview 6/25/15, at 9:02 a.m. with social services (SS)-A stated that residents should not be dressed and left to sleep before they are ready to get up for the day.

During interview on 6/25/15, at 9:06 a.m. registered nurse (RN)-A stated the staff should not be getting the residents up, dressed and leaving them to sleep in bed until it was time for them to get up for brunch. They should wait to dress them when they are ready to get up for the day.

A facility policy was requested on dignity for the residents and none was provided.

R2's diagnoses, as identified on the quarterly Minimum Data Set (MDS), dated 6/25/2015, included Alzheimer's and Parkinson's diseases. The MDS also indicated R2 was severely cognitively impaired, and further that she needed extensive, one-person, physical assistance with activities of daily living, including eating.

During observation on 6/24/2015 at 7:47 a.m., nursing assistant (NA)-C completed routine morning cares for R2, who was now dressed and seated in the wheel chair in her room. NA-C

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rearranged a positioning device on R2's wheel chair, then opened a small container of yogurt she had brought into the room, and placed a small cup of ice water on the dresser near R2's bed. NA-C, standing beside the wheel chair, began feeding R2 yogurt with a plastic spoon. NA-C gave R2 two consecutive bites of yogurt, then offered her water, saying, "It's pretty cold, uh?" NA-C then asked R2 "Do you want another drink?", as she stood next to R2, again spooning another spoonful of yogurt into R2's mouth. As R2's head moved from side to side, her arms were gently flailing, NA-C walked around R2, then approached from the other side, and continued feeding her. NA-C, continuing to stand while feeding, offered R2 more water, and the last spoonful of yogurt. At 7:51 a.m., four minutes after she began, NA-C was finished feeding R2 breakfast.

In an interview on 6/24/2015 at 11:41 a.m., NA-C stated that R2 usually "only eats yogurt for breakfast, and that was a family request." NA-C also said, R2 often was fed breakfast "in her room." NA-C acknowledged that she fed R2 earlier this morning in her room, and she fed R2 all the while standing up next to her.

During an interview on 6/25/2015 at 10:25 a.m., NA-D also said R2 would have a light breakfast in her room, and added, "you would want to take some time to feed [R2]." NA-D said, "It is a 'no no' to feed a resident while standing." NA-D also said feeding a resident while standing was "Not dignified."

In an interview on 6/25/2015, registered nurse (RN)-A said, "We do not assist [feeding] people standing." Further, RN-A stated, regardless if a

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F 241	Continued From page 5 resident was in the dining area, or in their own room, feeding them while standing was "not appropriate." In an interview on 6/25/2015 at 1:07 p.m., the director or nursing (DON) said that assistance provided to a resident while eating "should be at their level to provide dignity for the resident." A facility policy, Feeding Residents, undated, listed numerous tasks under "procedure", including: #12 Sit in a chair to feed the resident; #15 do not rush the resident; and #17 Do not rush the resident. The policy identified its purpose as "Feeding residents who have difficulty eating will provide adequate nutrition and attractive, well-balanced meals."	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, and monitor skin conditions for 1 of 6 residents (R31) reviewed for skin concerns. Findings include:	F 309	F309 It is the policy of St. Clare Living Community to provide or maintain the highest practicable quality of care for physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of	8/4/15

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F 309	Continued From page 6 R31's quarterly minimum data set (MDS) dated 4/16/15 indicated she was severely cognitively impaired, required extensive assist of two staff for all cares and did not ambulate. The 4/16/15 facility Observation Report identified risk factors and interventions which included; peripheral vascular disease, incontinence, skin check daily with cares, and licensed nurse to do skin inspection on bath day. R31's care plan dated 4/29/15 indicated she was at risk for altered skin integrity related to osteoarthrosis, peripheral vascular disease and lumbago and directed staff to monitor skin daily with cares with licensed nurse inspecting skin weekly with cares and a skin assessment at least quarterly. During an observation on 6/24/15, at 7:12 a.m., R31 was lying on her right side in bed with her left foot out of the blankets. R31's toes were disfigured and there was a small black area of eschar present on the third digit between the knuckle and the nail. At 7:51 a.m., R31 was sitting up in her wheel chair wearing socks and slippers on both of her feet. During interview on 6/24/15 at 8:55 a.m., registered nurse (RN)- C stated, R31 has "a chronic thing with her toes." She stated her toes had been treated with skin prep for quite a while. RN-C further stated that R31 had rolled out of bed and skinned her toe at one point and that the toe didn't get worse but "does not want to heal." During interview on 6/24/15, at 11:33 a.m., RN-A stated, the wound on R31's right foot was being documented as a corn/callous and had seen podiatrist on 4/30/15. The nurse practitioner was	F 309	care. To assure continued compliance, following plan has been implemented: For R31, who still resides in the facility, a foot cradle was placed on the bed to prevent injury to her toe and her foot wear was changed to diabetic socks without seams. Her care plan and team sheet were updated to reflect this. Her skin assessment remains current and appropriate. She remains on the wound rounds and will continue to be seen weekly by the wound nurse. She remains on the list to see the podiatrist every quarter and PRN. The Skin Assessment Policy and procedure was created and reviewed by IDT July 2015 and implemented. For all other residents who may be affected by this, skin checks are done daily with cares and weekly by the licensed nurse. All skin issues are reported to the licensed nurse for appropriate assessment. Audits on skin assessments are being done to ensure all skin issues are treat timely and appropriately. These audits will be completed weekly for four (4) weeks, monthly for three (3) months and randomly thereafter. All staff will be educated on the Plan of Correction on July 23, 2015. The Director of Nursing or Designee will be responsible for compliance. Compliance Date: August 4, 2015	

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aware of the wound but RN-A was unsure what type of wound the nurse practitioner identified R31 had. RN-A was not aware of the black area on R31's left foot.

Review of podiatrist notes dated 4/30/15, indicated R31 was being evaluated and treated for "painful nail deformities as well as generalized foot care." The notes further indicated R31 complained of painful callous of gradual onset and the "...condition is exacerbated by wearing shoe gear which causes pressure." The note further indicated R31 had vascular compromise and was "at risk for ulceration and/or infection."

Review of the facility Resident Progress Notes dated 4/22/2015 identified, "Wound team rounds: Res [resident] right foot 2nd digit [toe] corn is stable. No drainage, redness or odor noted. Res has another corn this is at the tip of the same toe and remains intact. No drainage, redness or odor noted. Res denies pain, Will continue to monitor. See wound assessment flow sheet for measurements and characteristics."

Review of the weekly St Clare Living Community of Mora Wound Reviews form from 4/22/15 to 6/17/15 identified the "right foot 2nd digit corn". The forms identified length, width, depth, wound base, drainage, undermining/tunneling, and current treatment. There was no indication that any black area on R31's left foot had been identified or monitored by the facility.

During an observation and interview on 6/24/15, at 2:40 p.m., of R31's left foot, the nurse practitioner (NP)-A stated, "I don't think it looks like pressure, looks more like a blood blister." The NP began touching the bottom of R31's feet

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F 309	Continued From page 8 and R31 was unable to feel her touch on either foot. NP further stated in regard to her (R31's) wounds, "My suspicion would be a vascular type of ulcer." She further stated, "I have not been following her feet, I have not seen her toes before." During a subsequent interview on 6/25/15, at 1:33 p.m., RN-A stated that the resident (R31) does not wear shoes. She stated R31 has no specific skin care treatments for her feet and she was unaware R31 had a black area on her left foot. Although R31 had risk factors of peripheral vascular disease, and staff were to monitor her skin daily with cares and weekly with a licensed nurse. There was no indication the black area on R31's left foot had been identified or consistently monitored by the facility. A policy on skin care and prevention was requested but not received.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		8/4/15

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F 315	Continued From page 9 by: Based on observation, interview and document review, the facility failed to comprehensively assess a change in urinary incontinence status for 1 of 1 (R83) reviewed who had a change in incontinence status. 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. R83's quarterly MDS dated 5/29/15, indicated she was now frequently incontinent of urine and needed extensive assist with toileting and transfers, which was a change from the previous MDS dated 3/20/15. R83's facility Observation Report dated 3/14/15, indicated she was currently continent of bladder, alert and oriented, able to verbalize and recognize the urge to urinate and appropriate place to do so. Requires assistance of two for transfers and needs assistance with toileting cares due to sling/cast on left arm. The report identified to continue to assist with toileting and they would initiate the the plan of care. A	F 315	F315 It is the policy of St. Clare Living Community that based on the resident¿s comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident¿s clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. To assure continued compliance, following plan has been implemented: For R83, who still resides in the facility, a new Bowel and Bladder assessment was completed on June 24, 2015. Care plan and team sheet are current and appropriate. The Urinary Continence Policy and Procedure was created and reviewed by the IDT July 2015 and implemented. For all other residents who may be affected by this, a new check list schedule of assessments for MDS¿ was developed with the bladder assessment included, and is being followed by the Nurse Managers completing the assessments. An audit of MDS assessments is being done to ensure all appropriate assessments have been completed for each MDS. These audits will be completed weekly for four (4) weeks, monthly for three (3) months and randomly thereafter. All staff will be educated on the Plan of	

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F 315	Continued From page 10 progress note dated 5/29/15, identified the resident remains incontinent of urine and continent of bowel. Resident is assistance of one with toileting and pericare. "Res [resident] able to request assist with toileting. Nsg [nursing] encourages fluids. Monitor for urinary s/sx [signs and symptoms]". Review of the facility Point of Care Bowel/Bladder Category Report from 3/14/15 to 3/20/13, identified R83 was only incontinent once. The 5/23/15 to 5/29/15, facility Point of Care Bowel/Bladder identified R83 was incontinent 21 times during this time frame. During observation 6/24/15, at 7:48 a.m. R83 was observed to be toileted by nursing assistant (NA)-A. R83's brief was wet, and she had been incontinent of urine. During interview 6/24/15, at 11:33 a.m. licensed practical nurse (LPN)-A stated she completed the MDS's but does not do the reassessments. She stated after reviewing R83's record information, that R83 had an increase in her urinary incontinence and if there are any changes they need to reassessed her incontinence. During interview 6/24/15, at 11:54 a.m. nursing assistant (NA)-A stated R83 "is usually wet in the morning and if we remind her to toilet she can stay dry during the day". During interview 6/24/15, at 12:27 p.m. registered nurse (RN)-A stated she completed the assessments and just realized R83's incontinence status had changed and she should have been reassessed for urinary incontinence when her quarterly MDS was completed in May	F 315	Correction on July 23, 2015. The Director of Nursing or Designee will be responsible for compliance. Compliance Date: August 4, 2015 F315 Addendum 7/28/15 For all others who may be affect by this IE: new admissions, and resident¿s with new MDS¿s due or residents who are incontinent of urine will be identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible by ¿ Start new 3 day void ¿ Complete a new bladder assessment ¿ Determine type of incontinence ¿ Review bladder collection data for individualized toileting patterns- add to care plan and NAR sheet ¿ Audit for timely toileting according to individualized plan ¿ Audits weekly for four weeks, monthly for three months, then randomly thereafter	

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F 315	Continued From page 11 2015. RN-A further stated she will also look at her voiding pattern to see if she needs to be placed on a toileting plan. The facility policy Villa Health Care Center Bowel and Bladder Assessment dated 8/06, indicated the purpose is to maintain or restore optimal bowel and bladder functions. All residents will have a Bowel and Bladder Assessment completed upon admission, quarterly, and with significant changes. All residents who are incontinent upon admission or have a change in their continence will have a 3-day Bowel and Bladder diary completed.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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: R12's quarterly Minimum Data Set (MDS), dated 5/28/15, indicated severe cognitive impairment	F 323	F323 It is the policy of St. Clare Living Center that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. To assure continued compliance, the following plan has been implemented: For R12, the anti-tip bars were placed	8/4/15

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F 323	Continued From page 12 and diagnoses including Alzheimer's disease, obsessive-compulsive disorder, and anxiety disorder. The MDS further indicated R12 was totally dependent upon staff for transfers and locomotion on and off the unit. R12 was observed on 6/23/15 at 3:39 p.m., sitting in her Tilt-N-Space wheelchair (chair that has tilt and recline capabilities) in her room with her chair tilted back at an approximate 50 degree angle. R12 was moving her arms up and down and back and forth causing forceful jerking movements while seated in the chair. The anti-tip bars (devices used to prevent a patient from tipping their wheelchair over backwards) on R12's wheelchair were in the up position, negating the purpose of the antitip bars. During observation on 6/24/15 at 11:03 a.m., R12 was observed in her Tilt-N-Space wheelchair in the day room. Her chair was tilted an an approximate 40 degree angle. She was coughing intermittently and when she coughed her arms were jerking, which lasted approximately 10 minutes. The anti-tip bars were again observed to be in the up position. During an interview on 6/24/15, at 11:16 a.m. nursing assistant (NA)-E stated, "I would assume [R12]'s anti-tipper bars are suppose to be down, I am not sure why hers are up." NA-E also stated, R12 "does not sit contently, she often screams out." When interviewed on 6/24/15, at 11:23 a.m. registered nurse (RN)-B stated she was not too familiar with the wheelchairs and was not aware if R12 needed her anti-tipper bars up or down. RN-B then said, "I will have to look into this."	F 323	while the surveyor was present. The care plan and team sheet were updated to reflect the change. A Wheel Chair and Specialized Wheel Chair Equipment use Policy and Procedure was created, reviewed by IDT and implemented July 2015. For all other residents who may be affected by this, audits are being done on wheel chair accessories that are placed for safety to ensure all measures are appropriate and the least restrictive. These audits will be completed weekly for four (4) weeks, monthly for three (3) months and randomly thereafter. All staff will be educated on the Plan of Correction on July 23, 2015. The Director of Nursing or Designee will be responsible for compliance. Compliance Date: August 4, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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) COMPLETION DATE
F 323	Continued From page 13 During an interview on 6/24/15, at 11:32 a.m. NA-B stated, "I am not sure why [R12] has the anti-tipper bars on her wheelchair. I never use them." NA-B further stated, "Some days [R12] moves around a lot in her chair." When interviewed on 6/24/15, at 11:38 a.m. RN-A stated, "The tilt bars should be turned around and not in the up position." RN-A further stated, "They are not doing any good in the up position, they should be in the down position." RN-A stated, "I will fix it right now" and proceeded to position the anti-tipper bars in the correct, down position. During interview on 6/24/15, at 12:26 p.m. occupational therapist (OT-A) stated, "The anti-tippers should be in the down position and being used at all times." When interviewed on 6/25/15, at 2:37 p.m., the assistive technology professional, (ATP) from Reliable Medical Supply (RMS), stated anti-tip bars were on wheelchairs as a safety mechanism. The ATP further stated, if someone had movements that jerk the chair, "the anti-tip bars should be in the down position." In addition, the ATP stated if [R12] has movements while in her chair, "the anti-tippers should be in the down position" and anyone that has a tilt chair, which is tilted back, "should always have the anti-tippers in the down position." A wheelchair safety device policy was requested from the facility, but not provided.	F 323		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		8/4/15

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	245291	A. BUILDING _____ B. WING _____	06/25/2015

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

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F 465	Continued From page 14 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were clean and odor free for 1 of 3 residents (R5), whose rooms on the north wing were observed for cleanliness. Findings include: R5's annual Minimum Data Set (MDS), dated 4/17/2015, identified R5 was moderately, cognitively impaired, had diagnoses which included neurogenic bladder, and had an indwelling catheter. R5's care plan, updated 4/17/2015 indicated R5 needed the assistance of one with toileting, per request, and also required the assist of one with clothing management. During the initial tour of the facility on 6/22/2015 at 2:01 p.m., there was a strong, lingering smell of urine inside R5's room, as well as in the hallway immediately outside R5's room. During observation of morning cares in R5's room on 6/24/2015 at 7:09 a.m., there again was present a strong, permeating smell of urine in R5's room. Urine odor was also present on R5's bed and bedding, as well as from a blanket laying on top of the bed. In an interview on 6/24/2015 at 7:20 a.m., registered nurse (RN)-C said there was a smell of	F 465	F465 It is the policy of St. Clare Living Community to provide a safe, functional, sanitary and comfortable environment for residents. Staff and the public. To assure continued compliance, following plan has been implemented: For the one room cited, a new mattress was placed on the bed; all personal blankets and clothing were laundered. The resident¿s shower schedule was changed from twice weekly to three times weekly with bedding changes each shower day. The closet was cleaned and sterilized. A Rubbermaid container with lid was obtained to store the catheter supplies. The resident¿s personal recliner was steam cleaned. The resident no longer uses the recliner and family removed it from the room. The Housekeeping Daily Room Cleaning Policy and Procedure were created, reviewed by IDT and implemented July 2015. For all other residents who may be affected by this, audits are being completed. These audits will be completed weekly for four (4) weeks, monthly for three (3) months and randomly thereafter. All staff will be educated on the Plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING _____ B. WING _____	06/25/2015

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

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F 465	Continued From page 15 urine in R5's room, and thought the odor "possibly came from [R5]'s personal clothing or blankets." RN-C also stated R5 was at risk for urinary tract infections because of her catheter use, and that R5 "was not a big, fluid drinker." RN-C said the nursing assistants drain R5's catheter bag "two to three times each shift," and that the urine collection devices were "cleaned with vinegar solution," and stored in R5's closet. During an interview on 6/24/2015 at 7:27 a.m., nursing assistant (NA)-A said there was urine odor in R5's room, and that R5's urine was often strong. NA-A also said R5 needed encouragement to drink fluids. The bedding in the residents' rooms were changed "once weekly on resident bath days," and as needed. NA-A was not sure how often residents' personal blankets were cleaned. 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."	F 465	Correction on July 23, 2015. The Director of Maintenance or Designee will be responsible for compliance. Compliance Date: August 4, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING _____ B. WING _____	06/25/2015

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

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F 465	Continued From page 16 During observation on 6/25/2015 at 8:27 a.m., there again was a distinct, lingering odor of urine in R5's room, and adjacent hallway. In an interview on 6/25/2015 at 8:29 a.m., RN-A said "I do smell urine, and have noticed the smell" in R5's room. RN-A stated she did not think there was a problem with the collection devices, nor suspect a problem with R5's catheter. RN-A said, that R5's room needed "more frequent bedding changes, and a stronger cleaning of the beds and linens." RN-A also thought a more thorough cleaning of R5's "personal laundry items, including blankets," 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. A facility policy "Thorough Cleaning Room after Resident Leaves," revised 3/26/2013, included direction for staff regarding what cleaning was expected after a resident is discharged from the facility. The policy did not address the day-to-day room cleaning, such as the frequency of cleaning for resident rooms and personal items, or direction on ways to reduce and eliminate odors.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLARE LIVING COMMUNITY OF MORA	**110 NORTH 7TH STREET MORA, MN 55051**

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K 000	INITIAL COMMENTS 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 in 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. St. Clare Living Community of Mora is a 1-story building with small partial basement. The original building was constructed in 1969 and additions constructed in 1999. The 1969 building is of type II(111) construction and the 1999 building is type V(111) construction. To the north a single story type V(111) assisted living facility also adjoins and is separated by 2 hour construction with a 90 minuted rated, self closing door. Another addition of Type V(111) construction opened to the west in 2005, therefore the building was inspected as 2 buildings. 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 facility has a licensed capacity of 65 beds and had a census of 45 at the time of the inspection. The requirement at 42 CFR Subpart 483.70(a) is Met.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING **02 - VILLA HEALTH CARE CENTER** B. WING _____	**06/23/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY Building #2 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 Building #2, the 2005 addition, was in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. St. Clare Living Community of Mora (Building #2) is a one story building story building with no basement The building was constructed in 2005 Type V (111) construction. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility has a licensed capacity of 65 and a census of 45 at the time of inspection.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00814	A. BUILDING: _____ B. WING _____	06/25/2015

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2 000	Initial Comments *****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 notice of assessment for non-compliance. 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On June 22-25th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, and monitor skin conditions for 1 of 6 residents (R31) reviewed for skin concerns. Findings include: R31's quarterly minimum data set (MDS) dated 4/16/15 indicated she was severely cognitively impaired, required extensive assist of two staff for all cares and did not ambulate. The 4/16/15 facility Observation Report identified risk factors and interventions which included; peripheral vascular disease, incontinence, skin check daily	2 830	Corrected	7/20/15

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2 830	Continued From page 3 with cares, and licensed nurse to do skin inspection on bath day. R31's care plan dated 4/29/15 indicated she was at risk for altered skin integrity related to osteoarthrosis, peripheral vascular disease and lumbago and directed staff to monitor skin daily with cares with licensed nurse inspecting skin weekly with cares and a skin assessment at least quarterly. During an observation on 6/24/15, at 7:12 a.m., R31 was lying on her right side in bed with her left foot out of the blankets. R31's toes were disfigured and there was a small black area of eschar present on the third digit between the knuckle and the nail. At 7:51 a.m., R31 was sitting up in her wheel chair wearing socks and slippers on both of her feet. During interview on 6/24/15 at 8:55 a.m., registered nurse (RN)- C stated, R31 has "a chronic thing with her toes." She stated her toes had been treated with skin prep for quite a while. RN-C further stated that R31 had rolled out of bed and skinned her toe at one point and that the toe didn't get worse but "does not want to heal." During interview on 6/24/15, at 11:33 a.m., RN-A stated, the wound on R31's right foot was being documented as a corn/callous and had seen podiatrist on 4/30/15. The nurse practitioner was aware of the wound but RN-A was unsure what type of wound the nurse practitioner identified R31 had. RN-A was not aware of the black area on R31's left foot. Review of podiatrist notes dated 4/30/15, indicated R31 was being evaluated and treated for "painful nail deformities as well as generalized	2 830		

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2 830	Continued From page 4 foot care." The notes further indicated R31 complained of painful callous of gradual onset and the "...condition is exacerbated by wearing shoe gear which causes pressure." The note further indicated R31 had vascular compromise and was "at risk for ulceration and/or infection." Review of the facility Resident Progress Notes dated 4/22/2015 identified, "Wound team rounds: Res [resident] right foot 2nd digit [toe] corn is stable. No drainage, redness or odor noted. Res has another corn this is at the tip of the same toe and remains intact. No drainage, redness or odor noted. Res denies pain, Will continue to monitor. See wound assessment flow sheet for measurements and characteristics." Review of the weekly St Clare Living Community of Mora Wound Reviews form from 4/22/15 to 6/17/15 identified the "right foot 2nd digit corn". The forms identified length, width, depth, wound base, drainage, undermining/tunneling, and current treatment. There was no indication that any black area on R31's left foot had been identified or monitored by the facility. During an observation and interview on 6/24/15, at 2:40 p.m., of R31's left foot, the nurse practitioner (NP)-A stated, "I don't think it looks like pressure, looks more like a blood blister." The NP began touching the bottom of R31's feet and R31 was unable to feel her touch on either foot. NP further stated in regard to her (R31's) wounds, "My suspicion would be a vascular type of ulcer." She further stated, "I have not been following her feet, I have not seen her toes before." During a subsequent interview on 6/25/15, at 1:33 p.m., RN-A stated that the resident (R31) does	2 830		

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2 830	Continued From page 5 not wear shoes. She stated R31 has no specific skin care treatments for her feet and she was unaware R31 had a black area on her left foot. Although R31 had risk factors of peripheral vascular disease, and staff were to monitor her skin daily with cares and weekly with a licensed nurse. There was no indication the black area on R31's left foot had been identified or consistently monitored by the facility. A policy on skin care and prevention was requested but not received. 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: R12's quarterly Minimum Data Set (MDS), dated 5/28/15, indicated severe cognitive impairment and diagnoses including Alzheimer's disease, obsessive-compulsive disorder, and anxiety disorder. The MDS further indicated R12 was totally dependent upon staff for transfers and locomotion on and off the unit. R12 was observed on 6/23/15 at 3:39 p.m., sitting in her Tilt-N-Space wheelchair (chair that has tilt and recline capabilities) in her room with her chair tilted back at an approximate 50 degree angle. R12 was moving her arms up and down and back and forth causing forceful jerking movements while seated in the chair. The anti-tip bars (devices used to prevent a patient from tipping their wheelchair over backwards) on R12's wheelchair were in the up position, negating the	2 830		

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2 830	Continued From page 6 purpose of the antitip bars. During observation on 6/24/15 at 11:03 a.m., R12 was observed in her Tilt-N-Space wheelchair in the day room. Her chair was tilted an an approximate 40 degree angle. She was coughing intermittently and when she coughed her arms were jerking, which lasted approximately 10 minutes. The anti-tip bars were again observed to be in the up position. During an interview on 6/24/15, at 11:16 a.m. nursing assistant (NA)-E stated, "I would assume [R12]'s anti-tipper bars are suppose to be down, I am not sure why hers are up." NA-E also stated, R12 "does not sit contently, she often screams out." When interviewed on 6/24/15, at 11:23 a.m. registered nurse (RN)-B stated she was not too familiar with the wheelchairs and was not aware if R12 needed her anti-tipper bars up or down. RN-B then said, "I will have to look into this." During an interview on 6/24/15, at 11:32 a.m. NA-B stated, "I am not sure why [R12] has the anti-tipper bars on her wheelchair. I never use them." NA-B further stated, "Some days [R12] moves around a lot in her chair." When interviewed on 6/24/15, at 11:38 a.m. RN-A stated, "The tilt bars should be turned around and not in the up position." RN-A further stated, "They are not doing any good in the up position, they should be in the down position." RN-A stated, "I will fix it right now" and proceeded to position the anti-tipper bars in the correct, down position. During interview on 6/24/15, at 12:26 p.m. occupational therapist (OT-A) stated, "The	2 830		

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2 830	Continued From page 7 anti-tippers should be in the down position and being used at all times." When interviewed on 6/25/15, at 2:37 p.m., the assistive technology professional, (ATP) from Reliable Medical Supply (RMS), stated anti-tip bars were on wheelchairs as a safety mechanism. The ATP further stated, if someone had movements that jerk the chair, "the anti-tip bars should be in the down position." In addition, the ATP stated if [R12] has movements while in her chair, "the anti-tippers should be in the down position" and anyone that has a tilt chair, which is tilted back, "should always have the anti-tippers in the down position." A wheelchair safety device policy was requested from the facility, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could train all staff and perform audits to ensure each resident is receiving appropriate nursing care and monitoring of non-pressure skin related issues. In addition, the director of nursing or designee could inservice staff regarding wheelchair safety devices, proper use of safety devices, and then audit for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 840		7/20/15

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2 840	Continued From page 8 adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a change in urinary incontinence status for 1 of 1 (R83) reviewed who had a change in incontinence status. 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. R83's quarterly MDS dated 5/29/15, indicated she was now frequently incontinent of urine and needed extensive assist with toileting and transfers, which was a change from the previous MDS dated 3/20/15. R83's facility Observation Report dated 3/14/15, indicated she was currently continent of bladder, alert and oriented, able to verbalize and recognize the urge to urinate and appropriate place to do so. Requires assistance of two for transfers and needs assistance with toileting cares due to sling/cast on left arm. The report	2 840	Corrected	

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2 840	Continued From page 10	2 840		

identified to continue to assist with toileting and they would initiate the the plan of care. A progress note dated 5/29/15, identified the resident remains incontinent of urine and continent of bowel. Resident is assistance of one with toileting and pericare. "Res [resident] able to request assist with toileting. Nsg [nursing] encourages fluids. Monitor for urinary s/sx [signs and symptoms]".

Review of the facility Point of Care Bowel/Bladder Category Report from 3/14/15 to 3/20/13, identified R83 was only incontinent once. The 5/23/15 to 5/29/15, facility Point of Care Bowel/Bladder identified R83 was incontinent 21 times during this time frame.

During observation 6/24/15, at 7:48 a.m. R83 was observed to be toileted by nursing assistant (NA)-A. R83's brief was wet, and she had been incontinent of urine.

During interview 6/24/15, at 11:33 a.m. licensed practical nurse (LPN)-A stated she completed the MDS's but does not do the reassessments. She stated after reviewing R83's record information, that R83 had an increase in her urinary incontinence and if there are any changes they need to reassessed her incontinence.

During interview 6/24/15, at 11:54 a.m. nursing assistant (NA)-A stated R83 "is usually wet in the morning and if we remind her to toilet she can stay dry during the day".

During interview 6/24/15, at 12:27 p.m. registered nurse (RN)-A stated she completed the assessments and just realized R83's incontinence status had changed and she should have been reassessed for urinary incontinence

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2 840	Continued From page 11 when her quarterly MDS was completed in May 2015. RN-A further stated she will also look at her voiding pattern to see if she needs to be placed on a toileting plan. The facility policy Villa Health Care Center Bowel and Bladder Assessment dated 8/06, indicated the purpose is to maintain or restore optimal bowel and bladder functions. All residents will have a Bowel and Bladder Assessment completed upon admission, quarterly, and with significant changes. All residents who are incontinent upon admission or have a change in their continence will have a 3-day Bowel and Bladder diary completed. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, and evaluate to assure residents who have a change in urinary incontinence to be reassessed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis	21426		7/20/15

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21426	Continued From page 12 infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. 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. Findings include: In review of the facility's, assessment, entitled: Facility Tuberculosis (TB) Risk Assessment Worksheet for health Care Settings Licensed by the Minnesota Department of Health (last reviewed 4/27/15), identified that the facility would be performing baseline TB screening at the time of admission, which the facility utilized the standards of the Minnesota Department of Health. In the review of 5 of 5 currently residing residents the following was noted: R41 had a the First Step TST (tuberculin skin test	21426	Corrected	

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21426	Continued From page 13 - PPD) given on 8/19/14 and read on 8/21/14 with "neg" (negative) only documented. The Second Step TST was given on 11/21/14 and read on 11/23/14, also documented as "neg". R41's chart lacked any evidence of a tuberculosis symptom screen being performed R50 had a the First Step TST given on 6/24/14 and read on 6/26/14 with "neg" (negative) only documented. The Second Step TST was given on 3/26/15 and read on 3/28/15, also documented as "neg". R50's chart lacked any evidence of a tuberculosis symptom screen being performed R8 had a the First Step TST given on 6/24/14 and read on 6/26/14 with "neg" (negative) only documented. The Second Step TST was given on 11/21/14 and read on 11/23/14, also documented as "neg". R8's chart lacked any evidence of a tuberculosis symptom screen being performed R10 had a chest x-ray performed due to a previous positive reaction. R10's chart lacked any evidence of a tuberculosis symptom screen being performed. R11 had a the First Step TST given on 5/29/15 and read on 9/31/15 with "neg" (negative) only documented. The Second Step TST was given on 6/8/15 and read on 6/11/15, also documented as "neg". R11's chart lacked any evidence of a tuberculosis symptom screen being performed. Four of the five residents (R41, R50, R8 and R11) TSTs were not documented in "mm" of induration, but rather "neg." During interview on 6/26/15 at 12:59 p.m., the acting director of nursing (A-DON) (acting) stated that "it appears that currently they facility is not	21426		

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21426	Continued From page 14 documenting TSTs results for resident correctly, not are we performing symptom screening as well." The A-DON further stated that this would be the expectation of the facility. During a interview on 6/26/15 at 1:20 p.m., the infection control nurse (RN) -N stated that she was unaware that documenting "neg" was needed to be done, and did not know symptom screenings for residents were not being completed. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review the facility's policy and procedures and educate the facility staff responsible for the provision of TB skin testing and symptom screening. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were clean and odor free for 1 of 3 residents	21695	Corrected	7/20/15

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21695	Continued From page 15 (R5), whose rooms on the north wing were observed for cleanliness. Findings include: R5's annual Minimum Data Set (MDS), dated 4/17/2015, identified R5 was moderately, cognitively impaired, had diagnoses which included neurogenic bladder, and had an indwelling catheter. R5's care plan, updated 4/17/2015 indicated R5 needed the assistance of one with toileting, per request, and also required the assist of one with clothing management. During the initial tour of the facility on 6/22/2015 at 2:01 p.m., there was a strong, lingering smell of urine inside R5's room, as well as in the hallway immediately outside R5's room. During observation of morning cares in R5's room on 6/24/2015 at 7:09 a.m., there again was present a strong, permeating smell of urine in R5's room. Urine odor was also present on R5's bed and bedding, as well as from a blanket laying on top of the bed. In an interview on 6/24/2015 at 7:20 a.m., registered nurse (RN)-C said there was a smell of urine in R5's room, and thought the odor "possibly came from [R5]'s personal clothing or blankets." RN-C also stated R5 was at risk for urinary tract infections because of her catheter use, and that R5 "was not a big, fluid drinker." RN-C said the nursing assistants drain R5's catheter bag "two to three times each shift," and that the urine collection devices were "cleaned with vinegar solution," and stored in R5's closet. During an interview on 6/24/2015 at 7:27 a.m., nursing assistant (NA)-A said there was urine	21695		

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21695	Continued From page 16	21695		

odor in R5's room, and that R5's urine was often strong. NA-A also said R5 needed encouragement to drink fluids. The bedding in the residents' rooms were changed "once weekly on resident bath days," and as needed. NA-A was not sure how often residents' personal blankets were cleaned.

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."

During observation on 6/25/2015 at 8:27 a.m., there again was a distinct, lingering odor of urine in R5's room, and adjacent hallway.

In an interview on 6/25/2015 at 8:29 a.m., RN-A said "I do smell urine, and have noticed the smell" in R5's room. RN-A stated she did not think there was a problem with the collection devices, nor suspect a problem with R5's catheter. RN-A said, that R5's room needed "more frequent bedding changes, and a stronger cleaning of the beds and linens." RN-A also thought a more

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21695	Continued From page 17 thorough cleaning of R5's "personal laundry items, including blankets," 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. A facility policy "Thorough Cleaning Room after Resident Leaves," revised 3/26/2013, included direction for staff regarding what cleaning was expected after a resident is discharged from the facility. The policy did not address the day-to-day room cleaning, such as the frequency of cleaning for resident rooms and personal items, or direction on ways to reduce and eliminate odors. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and bathrooms are kept clean and free of urine odors. Education could be provided to all appropriate staff on the policies and procedures and develop a monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		7/20/15

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21805	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified morning routine for 4 of 19 residents (R6, R60, R1 and R13) who required total assistance with dressing. Furthermore the facility did not provide a dignified dinning experience for 1 of 4 residents (R2) observed who required staff assistance to eat. Findings include: R6's quarterly Minimum Data Set (MDS) dated 6/4/15 indicated she was severely cognitively impaired and needed total assist of one with dressing and incontinent of urine. R6's care plan dated 6/4/15, indicated she required assist of one with dressing and prefers to rise at 8:00 a.m. During observation 6/23/15, at 8:35 a.m. R6 was dressed for the day in bed sleeping. During observation 6/25/15, at 8:39 a.m. R6 was observed to be asleep in bed with her day clothes of a pink sweatshirt on. During interview 6/25/15, at 8:43 a.m. nursing assistant (NA)-B stated that when she checked on R6 "at 6:30 a.m. and her pad was wet so I just washed her up then and dressed her". NA-B then stated she doesn't eat until brunch which is served at 10:30 a.m. so we don't get her out of bed until 9:45 a.m. R60's quarterly MDS dated 6/4/15, indicated he was severely cognitively impaired, needed extensive assist with dressing and was	21805	Corrected	

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21805	Continued From page 19	21805		

incontinent of urine. R60's care plan dated 6/19/15, indicated he needed extensive assist of one with dressing.

At 6/23/15, at 8:40 a.m. R60 was observed in bed dressed for the day with sheets pulled over him, asleep. On 6/25/15 at 8:43 a.m. he was again in bed already dressed for the day with a blue shirt on, asleep.

During interview 6/25/15, at 8:45 a.m. NA-B stated R60 was wet with urine so she dressed him in bed and left him to sleep until she would get him up for brunch that was served at 10:30 a.m.

R1's quarterly MDS dated 5/28/15, indicated he was severely cognitively impaired and needs total assist of one with dressing and was incontinent of urine. R1's care plan dated 5/28/15, indicated he needed assistance of one with all dressing. R1's facility's Freedom Design Getting To Know Me sheet dated 6/20/14, indicated he would "like to start his morning by getting up at 10ish".

During observation 6/23/15, at 9:01 a.m. R1 was observed in bed dressed for the day, asleep under the covers. On 6/25/15 at 8:00 a.m. R1 was again in bed dressed for the day in a tan button down shirt, sleeping.

R13's quarterly MDS dated 4/16/15, indicated she was severely cognitively impaired and needed total assist with dressing and was incontinent of urine. R13's care plan dated 6/17/15, indicated she needed total assist of one with dressing and grooming. R13's facility Freedom Design Getting To Know Me sheet 4/25/14 indicated she would

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21805	Continued From page 20 like to get up at 10:00 a.m. During observation 6/25/15, at 10:02 a.m. R13 was observed to be dressed in bed for the day asleep with a hoyer lift sheet under her. On 6/25/15, at 8:35 a.m. R13 was again dressed for the day in bed with a yellow shirt on, asleep. During interview 6/25/15, at 8:43 a.m. NA-B stated, her shift starts at 6:00 a.m. and when she does her first rounds if a resident is wet from urine she will dress them in bed since they are awake. They can go back to sleep if they want, because we do not get the residents up for brunch until 10:30 a.m. NA-B then stated they had been dressing residents while in bed, and having them go back to sleep for several years, since they started the five meal plan which includes brunch. NA-B further stated she had dressed R6 at 6:30 a.m. and R60 at 7:45 a.m. because they were both wet. NA-B stated she got R13 up at 6:10 a.m. because she was scheduled for a bath and after that they dressed her and placed her back into bed with her day clothes on so she could sleep until brunch. During interview 6/25/15, at 9:02 a.m. with social services (SS)-A stated that residents should not be dressed and left to sleep before they are ready to get up for the day. During interview on 6/25/15, at 9:06 a.m. registered nurse (RN)-A stated the staff should not be getting the residents up, dressed and leaving them to sleep in bed until it was time for them to get up for brunch. They should wait to dress them when they are ready to get up for the day. A facility policy was requested on dignity for the	21805		

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21805	Continued From page 21 residents and none was provided. R2's diagnoses, as identified on the quarterly Minimum Data Set (MDS), dated 6/25/2015, included Alzheimer's and Parkinson's diseases. The MDS also indicated R2 was severely cognitively impaired, and further that she needed extensive, one-person, physical assistance with activities of daily living, including eating. During observation on 6/24/2015 at 7:47 a.m., nursing assistant (NA)-C completed routine morning cares for R2, who was now dressed and seated in the wheel chair in her room. NA-C rearranged a positioning device on R2's wheel chair, then opened a small container of yogurt she had brought into the room, and placed a small cup of ice water on the dresser near R2's bed. NA-C, standing beside the wheel chair, began feeding R2 yogurt with a plastic spoon. NA-C gave R2 two consecutive bites of yogurt, then offered her water, saying, "It's pretty cold, uh?" NA-C then asked R2 "Do you want another drink?", as she stood next to R2, again spooning another spoonful of yogurt into R2's mouth. As R2's head moved from side to side, her arms were gently flailing, NA-C walked around R2, then approached from the other side, and continued feeding her. NA-C, continuing to stand while feeding, offered R2 more water, and the last spoonful of yogurt. At 7:51 a.m., four minutes after she began, NA-C was finished feeding R2 breakfast. In an interview on 6/24/2015 at 11:41 a.m., NA-C stated that R2 usually "only eats yogurt for breakfast, and that was a family request." NA-C also said, R2 often was fed breakfast "in her room." NA-C acknowledged that she fed R2 earlier this morning in her room, and she fed R2	21805		

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21805	Continued From page 22 all the while standing up next to her. During an interview on 6/25/2015 at 10:25 a.m., NA-D also said R2 would have a light breakfast in her room, and added, "you would want to take some time to feed [R2]." NA-D said, "It is a 'no no' to feed a resident while standing." NA-D also said feeding a resident while standing was "Not dignified." In an interview on 6/25/2015, registered nurse (RN)-A said, "We do not assist [feeding] people standing." Further, RN-A stated, regardless if a resident was in the dining area, or in their own room, feeding them while standing was "not appropriate." In an interview on 6/25/2015 at 1:07 p.m., the director or nursing (DON) said that assistance provided to a resident while eating "should be at their level to provide dignity for the resident." A facility policy, Feeding Residents, undated, listed numerous tasks under "procedure", including: #12 Sit in a chair to feed the resident; #15 do not rush the resident; and #17 Do not rush the resident. The policy identified its purpose as "Feeding residents who have difficulty eating will provide adequate nutrition and attractive, well-balanced meals." SUGGESTED METHOD OF CORRECTION: The administrator, director or nursing or designee could provide staff education related to dignified dining services and monitor for compliance. The facility director of nursing or designee could provide staff education with relation to dignified treatment of residents as it pertains to the time of day residents are dressed.	21805		

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21805	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		