DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2022

Administrator
St Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

RE: CCN: 245291
Cycle Start Date: April 21, 2022

Dear Administrator:

On May 5, 2022, we notified you a remedy was imposed. On May 26, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 26, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 4, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 5, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2022, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 26, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
May 5, 2022

Administrator
St. Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

RE: CCN: 245291
Cycle Start Date: April 21, 2022

Dear Administrator:

On April 21, 2022, a survey was completed at your facility by the Minnesota Department(s) 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 4, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 4, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 4, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Clare Living Community Of Mora will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 21, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 04/21/2022

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
E 000	Initial Comments On April 18th -21, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1)	E 041		5/26/22

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

Electronically Signed | 05/16/2022

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

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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records	E 041		

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E 041	Continued From page 2 Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012	E 041	It is the policy of St. Clare Living Community to provide a safe environment for all residents. For resident R40	

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E 041	Continued From page 3 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2.4 . These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 04/20/2022 at 09:00 AM, it was revealed by review of available documentation of the emergency generator maintenance and testing of weekly generator tests during the dates of 04/23/2021 and 04/15/2022 that 36/52 weekly inspections were completed and did not have all the required documentation. 2) On 04/20/2022 at 09:00 AM, it was revealed by review of available documentation of the emergency generator maintenance and testing of monthly generator tests during the dates of 04/2021 and 04/2022 could not be verified for all required monthly testing requirements. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	(resident room 151) cylinders and concentrator with trans fill adapter were removed from R40's room immediately on 4/20/22 when facility Director of Nursing was made aware of the concern and placed in the facility's oxygen storage room. R40 is currently on Allina Hospice case load and receives oxygen supplies through the Allina Hospice vendor. R40 given a concentrator and portable oxygen tank from the facility's oxygen vendor on 4/20222. For all other like residents affected by this practice, an audit on proper oxygen storage was completed 4/21/22. Nursing department meeting/education on proper storage of oxygen is scheduled for 5/19/22, and 5/24/22. For all residents who require oxygen therapy an audit on proper storage of oxygen will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the OA/OI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date Corrected 5/26/22	
F 000	INITIAL COMMENTS On 4/18/22 through 4/21/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care	F 000		

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F 000	Continued From page 4 Facilities. The following complaints were found to be UNSUBSTANTIATED: H5291037C(MN76922). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the multidisciplinary team (including the resident's primary physician) was involved in determining self administration of medication (SAM) for 2 of 2 residents (R40 and R150) for use of nebulizer treatments through a nebulizer machine (inhalation of medication treatment). Finding include: R40's Face Sheet undated, indicated R40's	F 554	It is the policy of St. Clare Living Community to allow residents the right to self-administer medications if it is determined clinically appropriate and safe for the resident to do so. For resident R40 and R150 self-administration of medications assessments were completed on 4/20/22. Resident R40 and R150 were deemed appropriate to self-administer nebulizer treatments after set up by Licensed Nurse/TMA. Order for residents R40 and	5/26/22

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F 554	Continued From page 5 diagnosis included malignant neoplasm of unspecified main bronchus, dyspnea (shortness of breath), pleural effusion (the build-up of excess fluid between the layers of the pleura outside the lungs) and respiratory failure. R40's significant change Minimum Data Set (MDS) dated 4/06/22, indicated R40 was moderately cognitively impaired, was independent with eating after set up, but required limited assistance with the rest of her activities of daily living. In a review of R40's Physician Order Report (undated) identified R40 was prescribed Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/ml (milligram/milliliter) 3 mg inhalation, 4 times a day for malignant neoplasm of main bronchus. R40's physician orders lacked evidence of R40's approval to self-administer medications. R40's Self-Administration of Medication Assessment (SAM) dated 4/05/22, indicated R40 did not wish to self-administer medications while at the facility. Observation on 4/20/22 at 7:21 a.m., registered nurse (RN)-B was just leaving R40's room. It was observed that R40 was sitting up on the edge of her bed, nebulizer canister / mouth piece in hand, nebulizer machine running. In an interview on 4/20/20 at 8:30 a.m., RN-B stated R40 was physically capable to perform her own nebulizer treatment and did not require supervision. R150's Face Sheet undated, indicated R40's diagnosis included malignant neoplasm of bronchus or lung and asthma. R150's admission	F 554	R150 was requested and received from NP on 4/20/22. Resident R40 and R50 care plans were reviewed and revised. Self-administration of medication policy was reviewed and revised on 5/9/2022 For all other like residents affected by this practice, self administration of medication assessments were completed 5/9/2022 and care plans were reviewed and revised as appropriate. Self- administration of medication assessments will be completed quarterly and with significant change in condition. Nursing department education on policy/procedure for self-administration of medications are scheduled for 5/19/22 and 5/24/22. For residents affected by this practice and all new admissions an audit on self-administration of medication assessments will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the OA/OI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date Corrected 5/26/22	

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F 554	Continued From page 6	F 554		

MDS dated 4/12/22, indicated R150 was cognitively intact, was independent with eating after set up, but required extensive assistance with the rest of her activities of daily living.

In a review of R150's Physician Order Report (undated) identified R40 was Albuterol sulfate 2.5 mg / 3 ml prescribed (0.083%) inhalation 1 vial twice a day and Ipratropium-Albuterol Solution 0.5 mg - 3 mg/ml (2.5 mg base) per 3 ml vial inhalation, 1 vial every 6 hours as needed. R150's physician orders lacked evidence of R150's approval to self-administer medications.

R150's Self-Administration of Medication Assessment (SAM) dated 4/07/22, indicated R150 did not wish to self-administer medications while at the facility.

During medication pass observation on 4/18/22, at 7:09 p.m. licensed practical nurse (LPN)-A set up R150's Albuterol inhalation treatment and after a short conversation left resident alone to perform the nebulizer treatment.

During further medication pass observation on 4/20/22, at 7:26 a.m. RN-B entered R150's room with morning neb treatment. After gathering the pieces from storage, placed Albuterol solution in the canister, handed it to the resident. R150 stated she would like toast after awhile and RN-B left the room leaving resident to treat self.

During interview on 4/20/21 at 8:30 a.m. RN-B stated that both R150 was physically capable to perform her own nebulizer treatment and did not require supervision.

In an interview on 4/20/22, at 12:51 p.m.

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F 554	Continued From page 7 registered nurse care manager (RN)-A stated both R40 and R150 have the ability to to self administer their own nebulizer treatments after staff set up. RN-A stated both R40's and R150's assessments lack evidence they were assessed for this ability, as well as, the facility lacked obtaining a physician's order for self administration of R40's and R150's nebulizer treatments. In an interview on 4/21/22 at 11:30 a.m., director of nursing (DON) stated all residents whom self-administer medications need to be assessed for their ability to safely perform and a physician's order obtained. In a review of the facility policy, entitled: Self Administration of Medications (reviewed February 2022), indicated residents who self-administer medications are required to be comprehensively assessed and reviewed by the interdisciplinary team (IDT), as well as, obtaining a physician order to include the specific medication(s) a resident will be self-administering.	F 554		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		5/26/22

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F 684	Continued From page 8 Based on observation, interview and document review, the facility failed to ensure adequate support of both legs and feet to promote good body alignment, and promote comfort for 1 of 2 residents (R30) reviewed for positioning. Findings include: R30's admission Minimum Data Set (MDS) dated 2/28/22, indicated R30 had significant cognitive impairment and required extensive assistance of two staff members to complete activities of daily living (ADL's) including dressing, grooming, and mobility. R30's diagnoses included non traumatic brain dysfunction (a change in brain function not related to injury), dementia (a change with the ability to think, reason, and communicate needs), depression (an alteration in mood state), and diabetes (a disease which affects the blood sugar in the body). R30's care plan, last reviewed/revised on 3/11/22, identified R30 experienced impaired mobility related to dementia, acquired absence of right great toe, and diabetes with diabetic neuropathy (a complication of diabetes where there is decreased sensation in extremities (hands/feet). In addition, the care plan indicated R30 had additional diagnoses, which included pain, disorder of bone density and structure, and muscle weakness. The careplan identified R30 received transfer assistance with one to two staff members with the use a Hoyer lift (a type of mechanical lift). R30 used a tilt in space wheelchair, which allowed R30 to self propel short distances. The care plan lacked direction as to use of foot pedals and calf rests. The South/North Group Sheet, dated 4/20/22,	F 684	It is the policy of St. Clare Living Community to provide quality care to all residents. St. Clare Living Community failed to ensure adequate support and body alignment with wheelchair positioning. For resident R50 a foot hugger with calf support was applied to residents wheelchair on 4/21/22. Care plan and care assignment sheet was reviewed and revised on 4/21/22 and on 5/11/22. Direct observation of resident and direct care staff interviews revealed resident can purposefully propel his tilt and space wheelchair using is upper extremities. Resident observed bringing right knee up at times when he is in his wheelchair and when he is in bed. Resident pain medication orders reviewed, resident receives Tylenol 1000mg TID, and Tylenol 1000mg X1 PRN. On 5/6/22 residents gabapentin was increased per NP to 300mg every morning, and 100mg every evening. Order obtained from NP for OT to eval a treat for wheelchair positioning and for muscle rub to be changed to twice a day versus as needed on 5/10/22. Pain assessment completed for 5/13/22. Resident does have his own custom tilt and space wheelchair. For all other like residents affected by this practice such as residents in broda/ tilt/space wheelchairs. Residents care plans reviewed and are up to date. Residents observed by Director of Nursing in their wheelchairs for proper body alignment during various times of the day. No concerns were observed with other like residents related to body alignment and no verbal/nonverbal signs	

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F 684	Continued From page 9 instructed staff to transfer R30 with the use of a Hoyer (lift) and assist of two staff members. The comments identified R30 had a left foot partial amputation, and additionally noted, "Knee pain muscle rub"[sic]. The group sheet lacked any information regarding the use of foot pedals. On 4/18/22, at 5:24 p.m. R30 was observed in the dining room, seated in his tilt in space wheelchair. R30 was noted to have gripper socks on feet with only toes resting on the floor. R30's wheelchair did not have foot rests or calf supports in place. On 4/19/22, at 2:16 p.m., R30 was observed in the main dining room during an activity. R30 was alert and seated in his wheelchair. R30 was unable to place his feet flat on the floor, and it was noted only R30's front portion of his feet touched the ground. R30 was observed during this time bringing his legs up to a hyperflexed position at times, primarily bring the right knee up towards chest. On 4/20/22, at 8:48 a.m. R30 was observed out in the dayroom, with only toes skimming the floor. R30 did not have foot pedals or calf supports in place on wheelchair. On 4/21/22, at 8:25 a.m. R30 was observed seated in his wheel chair in the day room. R30 was seated in an upright position in his tilt in space wheelchair. R30's toes were observed to touch the floor, however, he was unable place his feet flat on the floor. At 8:27 a.m. nursing assistant (NA)-A assisted R30 into a tilted position. R30 was then observed to have his legs dangling without any support of lower legs and feet. R30 was observed to pull right knee upward, and placed his right hand on his right	F 684	of pain observed with residents while up in wheelchairs. Prevention and Treatment of Skin Breakdown policy reviewed on 5/11/22 with no changes made. Nursing department meeting/education on 5/19/22 and 5/24/22. For residents affected by this practice an audit of wheelchair positioning and body alignment will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the OA/OI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance.	

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F 684	Continued From page 10	F 684		

knee. At 8:30 a.m. R30's left toes were observed to barely skim the floor. R30 was unable to touch the floor with his right foot. At 8:39 a.m. R30 was observed in the tilted position, and grasped his right knee in both hands in a hyperflexed position. R30 was then observed to let knee relax. R30's right foot remained suspended above the floor, unable to touch the floor. At 8:41 a.m. R30 was observed to pull his right knee up and hold it between both hands clasped over his right knee. R30 was observed to swing his toes of left foot over the floor in a back and forth motion. On 4/21/22, at 8:55 a.m. R30 was observed to bring both knees up, and was observed placing his left hand under left leg/knee. R30's facial expression was noted to have a furrowed brow, eyes closed, and facial muscles turned downward. At 8:57 a.m. R30 was observed to have his legs in a more relaxed position. R30 continued to have a furrowed brow, mouth movements in a chewing motion, alternating with a frowned expression.

During interview on 4/21/22, at 9:39 a.m., NA-A stated R30 was assisted earlier to tilt back in his chair as he was observed to be leaning forward in chair. During interview, R30 was seated in his room in an upright position with only his toes touching the floor. R30 was observed to bring his right knee up in hyperflexed position. NA-A stated although foot pedals were in his room, they were not used as R30 had historically attempted to move his wheelchair using his hands and feet. NA-A stated if foot pedals were in place, R30's ability to self propel his wheelchair would be impacted. NA-A stated R30 had historically brought knee(s) up, both while in bed and when sitting up, however, NA-A stated she was unaware of any concerns with R30's knee.

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F 684	Continued From page 11 On 4/21/22, at 10:02 a.m., licensed practical nurse (LPN)-D observed R30 in his wheelchair in an upright position. LPN-D stated R30 had pain in his right knee at times, and R30 drew his leg up during those times. Upon observing R30's position, LPN-D stated R30's legs and feet were not supported when seated in the wheelchair without the foot pedals with calf supports in place, and indicated there was potential for pain and altered blood flow. Additionally, LPN-D stated R30 was at risk for having his feet bumped and injured if he were propelled with foot support. On 4/21/22, at 11:24 a.m. the director of nursing stated she had observed R30 in his wheelchair without feet touching flat on the floor. DON stated lack of wheel chair foot pedals use would impact R30's comfort, as well as had the potential for injury to R30's feet. DON stated R30's foot pedals were to be applied to the wheelchair to promote good positioning and comfort. The DON stated staff were to be aware of R30's attempt to self propel wheelchair by removing feet from the foot pedals and using feet on the floor and were to address if this occurred. DON stated R30 would be unable to use feet to self propel with his feet if he were unable to touch the floor with both feet. The facility policy, Prevention and Treatment of Skin Breakdown, dated 6/14/21, identified it was important to provide proper positioning and good body alignment to prevent skin breakdown, relieve pressure, and provide proper circulation. Further, the policy identified staff were to assure resident's feet were positioned properly, either flat on the floor, or on footrests of the the wheelchair. The policy directed staff to seek out a Therapy evaluation for seating evaluation as appropriate.	F 684		

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F 880	Continued From page 12	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		5/26/22

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F 880	Continued From page 13 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to make sure staff were using personal protective equipment (PPE) according to the Center for Disease Control (CDC) guidelines during the COVID-19 pandemic. This had the potential to effect 47 of 47 residents, staff and visitors. Findings include:	F 880	It is the policy of St. Clare Living Community of Mora to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. St. Clare Living Community failed to make	

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F 880	Continued From page 14 On 4/18/22, the Center for Disease Control (CDC) COVID Data Tracker website indicated that Kanabec county community transmission rate was red or high. For health care workers, this means they were required to wear eye protection and face mask whenever in resident care area. On 4/18/22, at 3:15 p.m. nursing assistant (NA)-B and NA-C were observed performing cares on R2. Cares included brief change, pericare's and repositioning. NA-B and NA-C were observed to not have eye protection on. NA-B and NA-C were interviewed after completing cares. NA-B and NA-C stated that only masks needed to be worn currently and eye protection was not needed. NA-B and NA-C stated they were not aware what the current community transmission rate was. NA-B and NA-C stated they were told by either the scheduler or the charge nurse if eye protection was needed. On 4/18/22, at 6:03 p.m. licensed practical nurse (LPN)-B was observed leaving R8's room with her mask pulled down under her chin. LPN-B walked up to the cart and proceeded to pull meds for another resident. As LPN-B was pulling meds she pulled her mask over her mouth but her nostrils were still exposed. On 4/18/22, at 6:10 p.m., LPN-B was observed coming out of R5's room with her mask back down under her chin with mouth and nose exposed. LPN-B was observed pulling her mask back up over her mouth only after arriving back to the medication cart. LPN-B was interviewed at that time. LPN-B stated that a mask and gloves should be worn when working close and in contact with residents. LPN-B stated the mask should cover both the mouth and the nose	F 880	sure staff were using PPE according to CDC guidelines during the COVID-19 pandemic. St. Clare Living Community of Mora employees were not wearing eye protection, and staff not wearing surgical masks per facility policy for example mask were not covering bridge of nose. Facility Personal Protective Equipment policy reviewed/revised on 5/10/22. On 5/9/22 Administrator, DON, QMC, and Infection Preventionist (IDT) met and conducted RCA/Fishbone for PPE policy compliance. Infection Preventionist will have completed CMS Targeted COVID-19 Training for Managers and Infection Control F880, F881, F882, F883 through facility online training program Health Care Academy by 5/25/2022. Both courses are an accredited program. County Transmission rates will be checked every Thursday by IP and DON to ensure facility is complying with COVID-19 CDC guidelines during the pandemic. Any changes will be communicated to all employees through facility automated message system Voice Friend. All departments received the Personal Protective Equipment policy for review and signature of understanding and acknowledgement on 5/16/22. All managers received the PPE policy to post in their department on 5/16/22. For all residents affected by this practice the facility will conduct audits that include donning/doffing of PPE for residents on isolation precautions, general PPE (eye protection, surgical masks), residents on aerosolized generating procedures if applicable, and ensure appropriate	

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F 880	Continued From page 15 completely. LPN-B stated that eye protection was not needed at this time. LPN-B stated that some residents cannot hear through mask so the mask is removed while in room so residents can hear. LPN-B stated that mask removal is not suppose to be done in resident rooms. On 4/18/22, at 7:01 p.m. LPN-B was observed sitting with resident face to face with mask not covering mouth completely and was not covering nose at all. LPN-B was observed giving resident medications and assisting with drinking liquids by holding glass up to resident's mouth. LPN-B upper lip was observed rising above the level of the mouth when talking with resident. On 4/19/22, 10:59 a.m. health unit coordinator (HUC)-D and LPN-C were both observed sitting at nurses station in the commons area with masks down under their chins. Both mouth and nose was exposed. Nine (9) residents were noted to be throughout the commons area at this time. Interviews with HUC-D and LPN-C occurred at this time. Both stated that when in the commons area and around residents and staff in the facility a surgical mask would be worn covering both the nose and the mouth completely. On 4/19/22, at 11:05 a.m. trained medication aide (TMA)-D was observed standing at medication cart preparing meds in the hallway outside of resident rooms. TMA-D was observed with the surgical mask pulled up over the mouth loosely, but was not covering the nose at all. On 4/19/22, at 2:14 p.m. infection preventionist (IP)-C stated the community transmission rate was checked weekly. IP-C reviewed the CDC Covid data tracker website at that time and stated	F 880	preauction signage for residents who require isolation on all shifts, four times a week for one week, twice weekly for one week, and biweekly thereafter, until 100% compliance is achieved to ensure PPE/precaution criteria is being followed for all staff who enter the facility. Once 100% compliance is achieved facility will continue to conduct these audits randomly thereafter. The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the QAPI program/committee. Further system revisions and staff education will be provided if indicated by audits. The Director of Nursing, Infection Preventionist, or designee is responsible for compliance. Facility will continue to provide ongoing education of COVID-19 and Infection Control Policies for new employees and current employees as new guidance and policy updates becomes available. This education will be present via live all staff in-services, policy review/updates in written form, and facility on-line education program Health Care Academy.	

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F 880	Continued From page 16	F 880		

that the county was red (high) for community transmission rate. IP-C stated that red required wearing both mask and eye protection when in the facility and around residents. IP-C stated that a correctly worn mask would cover the mouth and the nose over the bridge of the nose. IP-C stated the expectation is all staff wear the appropriate PPE for the community level and the type of isolation resident is on, and that the PPE would be worn correctly.

CONTACT PRECAUTION ISOLATION

On 4/18/22, at 1:00 p.m., R29's room was observed to have an isolation cart in front of his room but no signage on door. Staff verified that R29 was on contact isolation precautions.

On 4/19/22, at 8:30 a.m., R29's room was observed to have an isolation cart in front of his room but no signage on door. Staff confirmed R29 was still on contact isolation precautions.

On 4/20/22, at 7:15 a.m., R29's room was observed to have an isolation cart in front of his room but no signage on door. Staff confirmed R29 was still on contact isolation precautions.

On 4/20/22, at 8:10 a.m. Welia phlebotomist (WP)-E was observed in R29's room, with mask and gloves on, but no isolation gown. R29 was on full contact precautions at that time. WP-E was interviewed right away after leaving room. WP-E stated there was an isolation cart outside the room but was unsure since there was no sign on the door indicating which kind. WP-E stated it was assumed the cart was just sitting there since there was no sign. WP-E stated that they should have checked with staff prior to entry to find out

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F 880	Continued From page 17 appropriate PPE while in the room. On 4/20/22, at 9:30 a.m., R29's door was observed to have a contact isolation precaution sign indicating gloves and a gown needed to be worn in room. 04/21/22, at 11:08 a.m., director of nursing (DON) stated staff should be wearing surgical masks and eye protection for resident care. DON stated masks need to be above the nose and form fitting to nose. DON eye protection should be worn based on community transmission level. Eye protection should be over eyes and not above head and have wrapping to go around, above and below the eyes. DON stated if a resident is on precautions for Covid-19 staff should also wear gown and shoe protection. DON stated expectation is that all staff follow policy and guidelines that explain what PPE is need for each specific type of isolation.	F 880		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in	F 886		5/26/22

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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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F 886	Continued From page 18 this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.	F 886		

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F 886	Continued From page 19 §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test 1 of 3 exempted from vaccination against COVID-19 staff (LPN)-B for Covid-19. Findings include: Review of facility staff vaccination status list undated, indicated licensed practical nurse (LPN)-B received an exemption from the Covid-19 vaccine on 1/26/22. Review of facility's monthly staff testing spreadsheet printed 4/18/22, indicated LPN-B last tested 3/30/22. The spreadsheet lacked any dates in April LPN-B Tested. Review of the facility's folder holding testing forms for the month of April lacked any testing forms for LPN-B , finished or unfinished. Review of facility's Covid-19 positive cases, undated, indicated the last positive staff and last positive resident was on 4/10/22. Review of The center for disease control (CDC) COVID data tracker webpage on 4/18/22, indicated Kanabec county community transmission level was red or high.	F 886	It is the policy of St. Clare Living Community to prevent the transmission of COVID-19 among residents and staff through routine testing per CDC guidelines, weekly review of community transmission levels, and outbreak testing within the facility. St. Clare Living Community failed to test employee exempted from vaccine against COVID-19 for COVID-19. Facility COVID-19 Exemption/Testing policy & transmission-based precautions reviewed/revised on 5/13/22. On 5/9/22 Administrator, DON, QMC, and Infection Preventionist (IDT) met and conducted RCA/Fishbone for testing exempt & vaccinated employees policy compliance. Infection Preventionist will have completed CMS Targeted COVID-19 Training for Managers and Infection Control F880, F881, F882, F883 through facility online training program Health Care Academy by 5/25/2022. Both courses are an accredited program. County Transmission rates will be checked every Thursday by IP and DON to ensure facility is complying with COVID-19 CDC guidelines during the pandemic. Testing may be increased during a facility outbreak. For example,	

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F 886	Continued From page 20 On 4/18/22, at 7:04 p.m., LPN-B stated she checks the community rate on her phone herself and tests based on the findings. LPN-B stated she checked the rate on 4/17/22, and showed county was low so she tested prior to her first shift today and will test again when she starts her first shift next week. LPN-B stated she only tested weekly at that time because, "that is what is required." LPN-B was not aware there was a difference between the county positivity rate and community transmission rate or which should be used. On 4/19/22, at 2:14 p.m. infection preventionist (IP)-C stated they had been in outbreak status since 4/10/22, when a resident and staff member were tested for Covid-19 and results came back positive. IP-C stated all staff were testing two times a week. IP-C stated when not in outbreak testing staff test based on the community transmission rate. IP-C stated that exempt staff should be tested at least weekly, more depending on the community transmission rate. IP-C stated the community transmission rate is checked on Tuesday of every week, sometimes more frequently. IP-C reviewed the CDC Covid data tracker webpage and stated the community transmission rate was high for Kanabec county. IP-C reviewed the monthly staff testing spreadsheet for April, and the folder of testing sheets for April and stated there were no dates in April where LPN-B had tested. IP-C stated LPN-B should be testing two times a week. 04/21/22, at 11:08 a.m. the director of nursing (DON) stated, the expectation is exempt staff base testing on what is going on in the facility and the county, testing right now is twice a week. DON stated that if not in outbreak and county	F 886	staff testing prior to their shift using BinaxNow COVID-19 Ag rapid tests. Any changes will be communicated to all employees through facility automated message system Voice Friend. For all residents affected by this practice the facility will conduct audits that include exempt and vaccinated employees on all shifts, four times a week for one week, twice weekly for one week, and biweekly thereafter, until 100% compliance is achieved to ensure testing criteria is being followed for all staff who enter the facility. Once 100% compliance is achieved facility will continue to conduct these audits randomly thereafter. The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the QAPI program/committee. Further system revisions and staff education will be provided if indicated by audits. The Director of Nursing, Infection Preventionist, or designee is responsible for compliance. Facility will continue to provide ongoing education of COVID-19 and Infection Control Policies for new employees and current employees as new guidance and policy updates becomes available. This education will be present via live all staff in-services, policy review/updates in written form, and facility on-line education program Health Care Academy.	

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F 886	Continued From page 21 community transmission rate is low then exempt employees test weekly. DON stated testing had to be performed either at a clinic or in the facility, home testing was not accepted. Facility policy COVID-19 Health Care Staff Vaccine and Testing, Resident Testing dated 11/5/21, and reviewed/revised date 3/22, indicated exempt, non-vaccinated employees would be tested for Covid-19 per Centers for Medicare & Medicaid Services (CMS) requirements. Policy stated routine testing of staff who are not up to date would be based on the community transmission rate. Minimum testing frequency of staff who were not up-to-date would be as follows: low testing not recommended, yellow test weekly, substantial testing twice a weekly and high testing twice a week. CMS policy QSO-20-38-NH revised 3-10-22 is referenced and attached to the policy.	F 886		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/20/2022. At the time of this survey, St. Clare Living Community of Mora was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as one building: St. Clare Living Community of Mora is a 1-story building with a small partial basement. The original building was constructed in 1969, and additions were constructed in 1999. The 1969 building is of type II(111) construction, and the 1999 building is type V(111) construction. To the north, a single-story type V(111) assisted living facility also adjoins and is separated by 2-hour construction with a 90-minute rated, self-closing door. Another addition of Type V(111)	K 000		

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K 000	Continued From page 2 construction opened to the west in 2005. 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 capacity of 65 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		5/6/22

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K 918	Continued From page 3 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3 and 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1 and 8.4.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 04/20/2022 at 09:00 AM, it was revealed by a review of available documentation of the emergency generator maintenance and testing of the generator that during the dates of 04/23/2021 and 04/15/2022 that 36/52 weekly inspections were completed. The weekly inspection and testing provided were missing the overall visual condition of the prime mover and the level of fluids. 2) On 04/20/2022 at 09:00 AM, it was revealed by a review of available documentation of the	K 918	It is the policy of St. Clare Living Community to provide a safe environment for all residents. St. Clare Living Community failed to document the overall visual condition of the prime mover, the level of fluids, temperature, oil temperature, and transfer switch operation. St. Clare Living Community Environmental Service Director adopted generator inspection audits from MDH engineering/life safety code web site which includes weekly visual inspections of prime mover, level of fluids, temperature, oil temperature, and transfer switch operations. Weekly generator inspections will be completed per life safety code of electrical systems. The Environmental Service Director or designee will be responsible for compliance. Date Corrected 5/6/2022	

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K 918	Continued From page 4 emergency generator maintenance and testing of monthly generator tests during the dates of 04/2021 and 04/2022 could not be verified for required monthly testing of the operating temperature, oil temperature, required cool down and transfer switch operations. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a	K 923		5/26/22

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K 923	Continued From page 5 minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen tanks in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, 11.6.2.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/20/2022 at 11:25 AM, it was revealed by observation in resident room 151, 2 oxygen tanks in the corner of the room that were not secured for tip resistance. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	It is the policy of St. Clare Living Community to provide a safe environment for all residents. For resident R40 (resident room 151) cylinders and concentrator with trans fill adapter were removed from R40's room immediately on 4/20/22 when facility Director of Nursing was made aware of the concern and placed in the facility's oxygen storage room. R40 is currently on Allina Hospice case load and receives oxygen supplies through the Allina Hospice vendor. R40 given a concentrator and portable oxygen tank from the facility's oxygen vendor on 4/20222. For all other like residents affected by this practice, an audit on proper oxygen storage was completed 4/21/22. Nursing department meeting/education on proper storage of oxygen is scheduled for 5/19/22, and 5/24/22. For all residents who require oxygen therapy an audit on proper storage of oxygen will be conducted 3 times per week for 30 days, weekly for 30 days, monthly for 3 months and randomly thereafter with results reported to the	

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K 923	Continued From page 6	K 923	OA/OI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Date Corrected 5/26/22	