MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245291

January 19, 2017

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 October 25, 2016 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.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HYMZ

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 **11/23/2016** (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 :
Austin Fry - HFE II 12/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath - Enforcement Specialist 01/19/2017 (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 01/19/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/03/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 16, 2016

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

RE: Project Number S5291026

Dear Mr. L'Heureux:

On September 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 15, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the September 15, 2016 standard survey has not yet been verified. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 15, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 15, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 15, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been

subject to a denial of payment. Therefore, St Clare Living Community Of Mora is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 15, 2016. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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 .

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 March 15, 2017 (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 electronic 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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 1, 2016

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

RE: Project Number S5291025

Dear Mr. L'Heureux:

On November 16, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 15, 2016. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of November 16, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 15, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on September 15, 2016, and failure to confirm substantial compliance by November 24, 2016. The most serious deficiencies at the time of the survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 23, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a survey, completed on September 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 25, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 23, 2016, as of October 25, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of . The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 15, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 15, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 15, 2016, is to be rescinded.

In our letter of November 16, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 15, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 25, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245291 Y1	A. Building B. Wing Y2	11/23/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0225	Correction	ID Prefix	F0226	Correction	ID Prefix	F0241	Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed	Reg. #	483.15(a)	Completed
LSC		10/25/2016	LSC		10/25/2016	LSC		10/25/2016
ID Prefix	F0242	Correction	ID Prefix	F0279	Correction	ID Prefix	F0282	Correction
Reg. #	483.15(b)	Completed	Reg. #	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.20(k)(3)(ii)	Completed
LSC		10/25/2016	LSC		10/25/2016	LSC		10/18/2016
ID Prefix	F0309	Correction	ID Prefix	F0311	Correction	ID Prefix	F0312	Correction
Reg. #	483.25	Completed	Reg. #	483.25(a)(2)	Completed	Reg. #	483.25(a)(3)	Completed
LSC		10/13/2016	LSC		10/18/2016	LSC		10/18/2016
ID Prefix	F0322	Correction	ID Prefix	F0369	Correction	ID Prefix	F0412	Correction
Reg. #	483.25(g)(2)	Completed	Reg. #	483.35(g)	Completed	Reg. #	483.55(b)	Completed
LSC		10/13/2016	LSC		10/18/2016	LSC		10/25/2016
ID Prefix	F0441	Correction	ID Prefix	F0465	Correction	ID Prefix	F0469	Correction
Reg. #	483.65	Completed	Reg. #	483.70(h)	Completed	Reg. #	483.70(h)(4)	Completed
LSC		10/18/2016	LSC		10/25/2016	LSC		10/25/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	12/01/2016	33925	11/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/15/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245291 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/23/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	10/13/2016	LSC K0025	10/25/2016	LSC K0027	10/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	10/07/2016	LSC K0052	10/25/2016	LSC K0054	10/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0070	09/15/2016	LSC K0144	10/25/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	12/01/2016	27200	11/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/15/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245291 Y1	A. Building 02 - VILLA HEALTH CARE CENTER B. Wing Y2	11/23/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	10/07/2016	LSC K0052	10/25/2016	LSC K0054	10/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	10/25/2016	LSC K0070	09/15/2016	LSC K0144	10/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 12/01/2016	SIGNATURE OF SURVEYOR 27200	DATE 11/23/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/15/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HYMZ

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: **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 **09/15/2016** (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:

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

X 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: **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 :
Michelle Koch, HFE NE II — 10/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/02/2016 (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
(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 11/03/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

****REVISED LETTER: This letter redacts and replaces the letters dated September 29, 2016 and October 5, 2016. The scope and severity for deficiency F 465 has been altered.****

Electronically delivered
October 14, 2016

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

RE: Project Number S5291025

Dear Mr. L'Heureux:

On September 15, 2016, 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
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
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 October 25, 2016, 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 December 15, 2016 (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 March 15, 2017 (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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

REVISED LETTER

Electronically delivered
October 5, 2016

Mr. Jack L'Heureux, Administrator
St. Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

RE: Project Number S5291025

Dear Mr. L'Heureux:

On September 15, 2016, 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 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 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:

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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
Brenda.Fischer@state.mn.us
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 October 25, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 25, 2016 the following remedy will be imposed:

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

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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 March 15, 2017 (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

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Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 29, 2016

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

RE: Project Number S5291025

Dear Ms. Udy:

On September 15, 2016, 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 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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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.

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Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Brenda.Fischer@state.mn.us
Telephone: (320) 223-7338
Fax: (320) 223-7348

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- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 25, 2016 the following remedy will be imposed:

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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;

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- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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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.

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

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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: 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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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 _____	09/15/2016

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 On 9/12/16 to 9/15/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). St. Claire Living Community was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		10/25/16

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

Electronically Signed | 10/07/2016

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F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure allegations of abuse were reported to the State Agency (SA) in a timely manner for 2 of 3 residents (R43, R42) reviewed for allegations of abuse. Findings include: R43's quarterly MDS dated 8/5/16, indicted R43 was cognitively intact. An undated face sheet, indicated R43's diagnoses included bilateral (both) lower extremity (legs) edema, diabetes, and chronic pain. On 9/12/16, at 2:27 p.m. with R43 stated the staff member was rude to R43 and the staff member stated R43 did not belong in the facility. On 9/14/16, at 11:33 a.m. a review of the incident	F 225	F225 Investigate/Report allegations/Individuals The facility has a very strong Vulnerable Adults Abuse Prevention Plan. All of the staff receives training on the VA Abuse Prevention Plan and the required reporting. It is also the policy of St. Clare□s to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents or misappropriation of their property. For Resident R43: On 9/12/16 at approximately 5:00 PM, the surveyor, as she was leaving for the day, approached the administrator to inform him that during	

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F 225	Continued From page 2 report submitted to the SA indicated R43 reported verbal abuse by a staff member on 9/12/16. The facility reported the incident to the SA on 9/13/16. R42's admission Minimum Data Set (MDS) dated 8/10/16 indicated R42 was cognitively intact. A face sheet undated, indicated R42's diagnoses included right and left tibia (bone in the lower leg) fractures, osteoporosis, and lupus (an inflammatory disease caused when the immune system attacks its own tissues). On 9/14/16, at 11:22 a.m. a review of the incident report submitted to the SA indicated R42 reported verbal abuse by a staff member on 9/7/16. The facility reported the incident to the state agency on 9/8/16. On 9/14/16, at 11:23 a.m. the director of nursing (DON) stated staff should report abuse concerns to the DON immediately when they discover the abuse. The DON stated the facility had 24 hours to report abuse to the SA from the time of the incident. The facility policy Abuse Prevention Plan for St. Clare Living Community of Mora dated 7/1/15, indicated to contact the SA via online report immediately upon receiving a report of possible abuse, neglect, and /or financial exploitation.	F 225	the resident interviews earlier that afternoon, R43 report to her that she was verbally abused by a staff member. Upon hearing this from the surveyor, the administrator immediately implemented the investigation process. R43 was interviewed by the LSW and the DON. The LSW entered the allegation into the Entry Point on 9/13/16. The Kanabec County Deputy Sheriff came in also on 9/13/16 and based on her investigation she felt that no further action was needed. The DON review R43□s care plan and assignment sheet and found that they were current and accurate. The AP in this incident is no longer employed by St. Clare□s. For Resident R42: One 9/7/16 It was reported to charge nurse of a suspected verbal abuse of R42. The charge nurse immediately investigated the allegation including interviewing R42 The VA report was filed with OHFC 9/8/16. The DON reviewed R42□s care plan and assignment sheet and found that they were current and accurate. The AP in this incident is no longer employed by St. Clare□s. For any residents having the potential to be affected by the same issue, our VA policy and reporting process will be discussed at the next Resident Council on 10/17/16. Additionally, all staff responsible for care for each resident has been educated on protocols for response to allegation and /or violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property,	

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F 225	Continued From page 3	F 225	allegation reporting timelines and investigative actions (including verbal abuse as described in the R42 & R43 incidents). The Director of Social Services, Director of Nursing and the Administrator has reviewed and revised the current VA policy. The expectation for reporting suspected abuse and neglect immediately was impressed upon the staff at the all staff meeting held 10/18/16. The IDT will review all incident reports at their daily morning meeting to ensure proper procedures were followed in the identification, investigation, and reporting of the incidents, including any suspected abuse/neglect. Any issues identified will immediately addressed with staff. Results of the reviews will be reported to the QA/QI committee for further review. The administrator and/or designee will be responsible for monitoring for on-going compliance to this requirement. Date of Correction: 10/25/16	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		10/25/16

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F 226	Continued From page 4 Based on interview and document review the facility failed to implement their abuse prohibition policy related to the immediate reporting to the State Agency (SA) for 2 of 3 residents (R42 and R43) reviewed for abuse allegation. Findings include: The facility policy Abuse Prevention Plan for St. Clare Living Community of Mora dated 7/1/15, indicated to contact the SA via online report immediately upon receiving a report of possible abuse, neglect, and /or financial exploitation. On 9/14/16, at 11:23 a.m. with the director of nursing (DON) stated staff should report abuse concerns to me immediately when they discover the abuse. The DON stated the facility had 24 hours to report abuse to the SA from the time of the incident. R42's admission Minimum Data Set (MDS) dated 8/10/16 indicated R42 was cognitively intact. A face sheet undated, indicated R42's diagnoses included a right and left tibia (a bone in the lower legs) fractures, osteoporosis, and lupus (an inflammatory disease caused when the immune system attacks its own tissues). On 9/14/16, at 11:22 a.m. a review of the incident report submitted to the SA indicated R42 reported verbal abuse by a staff member on 9/7/16. The facility reported the incident to the state agency on 9/8/16. R43's quarterly MDS dated 8/5/16, indicted R43 was cognitively intact. A face sheet undated, indicated R43's diagnoses included bilateral (both) lower extremity (legs) edema, diabetes, and chronic pain. On 9/12/16, at 2:27 p.m. with R43 stated the staff member was rude to R43 and the staff member stated R43 did not belong in the facility.	F 226	F226 Develop/implement Abuse/Neglect Policy The facility has a very strong Vulnerable Adults Abuse Prevention Plan. All of the staff receives training on the VA Abuse Prevention Plan and the required reporting. It is also the policy of St. Clare□s to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents or misappropriation of their property. (See plan of correction detailed in tag F225). For any residents having the potential to be affected by the same issue, our VA policy and reporting process will be discussed at the next Resident Council. Additionally, all staff responsible for care for each resident has been educated on protocols for response to allegation and /or violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, allegation reporting timelines and investigative actions (including verbal abuse as described in the R42 & R43 incidents). The Director of Social Services, Director of Nursing and the Administrator has reviewed and revised the current VA policy. The expectation for reporting suspected abuse and neglect immediately was impressed upon the staff at the all staff meeting held 10/18/16. The IDT will review all incident reports at their daily morning meeting to ensure proper procedures were followed in the identification, investigation, and reporting	

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F 226	Continued From page 5 On 9/14/16, at 11:33 a.m. a review of the incident report submitted to the SA indicated R43 reported verbal abuse by a staff member on 9/12/16. The facility reported the incident to the SA on 9/13/16.	F 226	of the incidents, including any suspected abuse/neglect. Any issues identified will immediately addressed with staff. Results of the reviews will be reported to the QA/QI committee for further review. The administrator and/or designee will be responsible for monitoring for on-going compliance to this requirement. Date of Correction: 10/25/16	
F 241 SS=D	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 rising routine for 1 of 1 residents (R1) reviewed for dignity. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/21/16, identified R1 had severe cognitive impairment, and was totally dependent on staff for bed mobility and transfers. During observation on 9/14/16, at 7:05 a.m. R1 was laying in bed in his room. R1 had a white button up shirt on, however was still lying underneath the blankets. R1 opened his eyes at times and looked around the room, then closed	F 241	F241 It is the policy of St. Clare Living Community to promote care for residents in a manner and an environment that maintains or enhances each resident□s dignity and respect in full recognition of her individuality. Resident R1 remains in the facility his care plan, and assignment sheet have been updated to reflect resident preferences for wake time per resident Freedom Design interview and/or family input. For all dependent residents who may be affected by this, care plans and assignment sheets have been reviewed and updated to reflect resident	10/25/16

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F 241	Continued From page 6 them and fell back asleep. At 9:24 a.m. R1 remained in bed, dressed with his eyes closed. On 9/14/16, at 11:26 a.m. nursing assistant (NA)-C stated another NA had dressed R1 earlier that morning and placed him back in bed. NA-C stated she was not sure why, "I don't know." Further, NA-C stated she had noticed, "other residents as well," being dressed then placed back into bed. However, NA-C didn't feel this was appropriate, "It's a dignity thing." During interview on 9/14/16, at 12:54 p.m. NA-D stated she had assisted R1 with getting dressed and placed him back in bed, "He was totally dressed." NA-D stated staff had typically dressed R1 and placed him back in bed, "since I started here," adding it was, "kinda what I was shown." Further, NA-D stated staff did this because they had other residents to assist with cares before the morning meal and couldn't help everyone at once. On 9/14/16, at 1:32 p.m. licensed practical nurse (LPN)-A stated staff getting R1 dressed then putting him back in bed was, "Kind of a normal practice," because staff had to have all the residents up and in the dining room for the meal. "[It's] more an issue of time constraint." On 9/14/16, at 1:45 p.m. registered nurse (RN)-B stated R1 should have been allowed to sleep in and assisted with dressing when he awoke for the day. Further stating, it would have been, "characteristic of a normal environment." A facility Maintaining Respect and Dignity policy dated 6/1/13, identified staff should, "Care for residents in a manner and environment that enhances each resident's dignity and respect,"	F 241	preferences per resident Freedom Design interview and/or family input. For residents who are unable to voice preferences will have a.m. cares completed per their Freedom Design interview/family input. Dignity audits, which includes auditing for "residents not dressed and left in bed after AM cares", will be conducted on dependent residents will be completed weekly for four weeks, monthly for three months, and randomly thereafter. All nursing staff will be educated on the dignity policy 10/18/16. The Director of Nursing or Designee will be responsible for compliance. Audit results will be reported to the QA/QI Committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Compliance Date: 10/25/16	

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F 241	Continued From page 7 and added a procedure which included, "Residents are dressed in their own clothes appropriate to the time of day and individual preferences."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor identified preferences for morning rising for 1 of 3 residents (R1) reviewed for choices. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/21/16, identified R1 had severe cognitive impairment, and was totally dependent on staff for bed mobility and transfers. R1's Freedom Design preference sheet dated 9/26/13, identified a spacing labeled, "I like to start my morning by getting up...". This was completed by staff with an identified preferred rising time of, "10 ish [around 10 a.m.]". On 9/14/16, at 7:05 a.m. R1 was laying in bed in his room. R1 had a white button up shirt on,	F 242	F242 It is the policy of St. Clare Living Community to promote care for residents in a manner and an environment that maintains or enhances each resident□s dignity and respect in full recognition of her individuality. Resident R1 remains in the facility his care plan, and assignment sheet have been updated to reflect resident preferences for wake time per resident Freedom Design interview and/or family input. For all dependent residents who may be affected by this, care plans and assignment sheets have been reviewed and updated to reflect resident preferences per resident Freedom Design interview and/or family input. For residents who are unable to voice	10/25/16

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F 242	Continued From page 8 however was still lying underneath the blankets. R1 opened his eyes at times and looked around the room, then closed them and fell back asleep. At 9:24 a.m. R1 remained dressed in bed with his eyes closed. When interviewed on 9/14/16, at 11:26 a.m. nursing assistant (NA)-C stated another NA had dressed R1 early that morning and placed him back in bed. NA-C stated she was not sure why, "I don't know." On 9/14/16, at 12:54 p.m. NA-D stated she had assisted R1 with getting dressed and placed him back in bed, "He was totally dressed." NA-D stated R1 liked to get up, "About 9:30 or quarter to ten," however staff typically dressed R1 and placed him back in bed in the early morning adding it was, "Kinda what I was shown." On 9/14/16, at 1:32 p.m. licensed practical nurse (LPN)-A stated staff getting R1 dressed then putting him back in bed was, "kind of a normal practice," because staff had to have all the residents up and in the dining room for the meal. "[It's] more an issue of time constraint." On 9/15/16, at 9:52 a.m. registered nurse (RN)-B stated R1's preferences for rising were determined by, "The wellness team," and recorded on his Freedom Design preference sheet. Further, RN-B stated staff, "Shouldn't be getting him dressed until 10 a.m." as it was his identified preference. A facility policy on choices with care was requested, but none was provided.	F 242	preferences will have a.m. cares completed per their Freedom Design interview/family input. Dignity audits, which include auditing for "residents not dressed and left in bed after AM cares", will be conducted on dependent residents will be completed weekly for four weeks, monthly for three months, and randomly thereafter All nursing staff will be educated on the dignity policy 10/18/16. Audit results will be reported the QA/QI Committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. The Director of Nursing or Designee will be responsible for compliance. Compliance Date: 10/25/16	
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		10/25/16

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F 279 SS=D	Continued From page 9 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan to monitor heart failure for 1 of 3 residents (R5) reviewed for hospitalization. In addition, the facility failed to develop a comprehensive care plan to monitor anticoagulant, antidepressant and diuretic medications for 1 of 5 residents (R105), reviewed for medications. Findings included: R5's Dehydration/Fluid Maintenance Care Area Assessment (CAA) dated 8/9/16, indicated R5	F 279	F279 It is the policy of St. Clare Living Community to use the results of assessment to develop, review and revise the resident□s comprehensive plan of care. For Residents # 5 and #105 the care plan was reviewed and revised on 9/16/16, and 9/19/16. Corresponding updates have been made to care assignment sheets and communicated to resident and/or designated decision maker. Education provided for licensed nursing staff	

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F 279	Continued From page 10 had newly present constipation, an infection of the foot and had a recent increase in diuretic dosage and was at risk for dehydration. The CAA also indicated R5 had diagnoses that included diabetes and congestive heart failure, that would predispose him to difficulty maintaining normal fluid balance. The CAA directed a care plan would be developed for a risk of dehydration. A physician's note dated 8/11/16, indicated that R5 had increased difficulty with fluid overload over the past week. R5 had been unable to tolerate therapy sessions and became short of breath with minimal exertion. The note also indicated R5 was lethargic and hard to arouse at the time of the visit and was sent to the emergency room for further evaluation. A physician's note dated 8/15/16, indicated R5 was hospitalized on 8/11/16, and returned to the facility on 8/14/16. R5 was hospitalized and administered intravenous diuretics. R5 had modest diuresis, weight was now down and had improved respiratory status, although R5's lower legs remained edematous. R5's physician orders dated 8/14/16, indicated R5 was taking furosemide (diuretic) 80 milligrams (mg) by mouth (po) twice a day (BID) for edema. The orders also directed staff to give R5 an additional dose of 160 mg po BID if his weight was up by three pounds, until weight returned to normal. The care plan dated 8/15/16, did not include a plan for fluid maintenance or a risk for dehydration. During interview on 9/15/16, registered nurse	F 279	members regarding documentation for change in condition, reassessment, and updating care plans along with policies on development of comprehensive care plan and change in condition on 10/13/16. For other like residents who may be affected by this practice, an audit on development of comprehensive care plans was completed on 10/14/16. Upon this review, care plan revisions and licensed nursing staff education will be implemented if indicated by 10/25/16. The policy for developing comprehensive care plans has been reviewed and revised by the interdisciplinary team. A review of policies by the Medical Director will be conducted to ensure current standards of practice are in place. Licensed nursing staff members were trained as it relates to their respective roles and responsibilities regarding the development of comprehensive care plans policy and procedure on 10/25/16. Weekly audits of comprehensive care plan completion will be completed for four weeks, monthly for 3 months, and randomly thereafter with results reported to QA Committee for review and further recommendation. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Compliance Date: 10/25/16.	

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	245291	A. BUILDING _____ B. WING _____	09/15/2016

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F 279	Continued From page 11	F 279		

(RN)-A stated that the facility was giving him his diuretics as ordered and monitoring his weights however, a care plan had never been developed related to fluid maintenance for R5, to monitor his fluid status.

When interviewed on 9/15/16, at 2:45 p.m. the director of nursing (DON) stated that a fluid maintenance care plan should have been developed for R5, to direct staff on what to monitor.

When interviewed on 9/15/16, at 2:52 p.m. the certified nurse practitioner (CNP) stated a care plan should have been developed to direct staff to weigh daily, monitor for shortness of breath and edema and to address any other fluid and diet concerns.

R105 was admitted to the facility on 8/20/16.

R105's admission Minimum Data Set (MDS) dated 8/26/16, indicated R105 was taking an anticoagulant, antidepressant and diuretic medications. The MDS included diagnoses of atrial fibrillation, heart failure and renal insufficiency.

R105's Physician orders dated 8/22/16, directed staff to administer trazodone (antidepressant used for sleep) 50 mg po at bedtime and can repeat the dose one time as needed for insomnia. Physicians orders dated 8/29/16, directed staff to administer furosemide 80 mg po BID for edema. Physician orders dated 9/7/16, directed staff to administer warfarin (an anticoagulant) 4 mg po six times per week , warfarin 6 mg po one time per week for atrial fibrillation.

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F 279	Continued From page 12 R105 had an undated temporary admission care plan, however the facility had not initiated a permanent care plan addressing the use of an anticoagulant, antidepressant or diuretic medications. On 9/15/16, at 2:04 p.m. RN-A stated that a permanent care plan had not been developed yet for R105. RN-A further stated the care plan was to be completed within 21 days of admission to the facility and she had not gotten around to it. RN-A stated the care plan should include direction for monitoring anticoagulant, antidepressant and diuretic medications. When interviewed on 9/15/16, at 2:40 p.m. the DON stated the permanent care plans were expected to be completed within 21 days of admission and monitoring for anticoagulants, antidepressants and diuretic medications absolutely should be part of the care plan. A policy on care plans was requested and was not received.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care plan to ensure assessed needs were met for 3 of	F 282	F282 It is the policy of St. Clare Living Community to provide care and services	10/18/16

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F 282	Continued From page 13 5 residents (R52, R70, R7) whose cares were reviewed. Findings include: R52's quarterly Minimum Data Set (MDS) dated 7/21/16, identified R52 had severe cognitive impairment, and required extensive assistance with eating. R52's care plan dated 8/3/16, identified R52 was at, "Nutritional risk," and directed staff to use, "Adaptive equipment at meals," to help R52, "Maintain stable weight." On 9/12/16, at 10:25 a.m. R52 was seated at a table in the main dining room. R52 had a white menu slip placed next to him on the table which identified his name, along with bolded print stating, "GIVE LIP PLATE @ [at] MEALS." At 10:41 a.m., R52 was served a plate of french toast with ground meat on a non-lipped, regular ceramic plate. Nursing assistant (NA)-D cut up R52's french toast and left the table to serve another resident. R52 picked up his fork and moved the ground meat around his plate, at times having the meat on the far edge of plate. On 9/13/16, at 5:01 p.m. R52 was seated in the main dining room. R52 had been served cheese casserole and an egg salad sandwich on a regular, non-lipped ceramic plate. R52 had a white menu slip placed on the table next to him which still identified, "GIVE LIP PLATE @ MEALS." R52 attempted to take bites of casserole using a regular spoon, at times spilling casserole onto the table and placemat. On 9/14/16, at 1:00 p.m. NA-D stated R52 is,	F 282	by qualified persons In accordance with each resident□s written plan of care. For resident□s # R52 the care plan reviewed and revised on 10/7/16. Corresponding updates have been made to resident□s individual meal tray card and communicated to the residents and/or designated decision maker. Education to NA/R's and Wellness staff members regarding adaptive equipment at meals and nutritional risks to maintain stable weight on 10/17/16. For residents who require assist with meals and adaptive equipment who are affected by this progress, an audit on nutritional risk care plans and continuing education of NA/R's and Wellness staff responsible for care was completed on 10/8/16. Upon this review care plan revisions and/or staff education implemented if indicated by 10/11/16. The policy for adaptive feeding equipment has been reviewed and revised by the interdisciplinary team. NA/R's and Wellness Staff members were trained as it relates to their respective roles and responsibilities regarding the adaptive equipment policy and procedure on 10/18/16. Meal service audits will be conducted three times per week for 30 days, then weekly for 30 days, then monthly for three months and randomly thereafter. Results will be reported to QA Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. For resident #R70 care plan and	

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F 282	Continued From page 14 "generally" served using a regular plate at meals. NA-D stated she was unaware what type of plate R52 should be using at meals. On 9/14/16, at 1:53 p.m. registered nurse (RN)-B stated nursing staff were expected to have access to the most recent care plan, and ensure it was being followed adding R52 was, "supposed to have a lipped plate." R70's care plan dated 3/8/16, indicated R70's shunt was in her right arm, received dialysis Monday, Wednesday and Friday and was at risk for bleeding due to heparin use at dialysis. The care plan directed the nurse to monitor the access site for redness, bleeding, pain and swelling, however did not direct staff on how frequent to monitor the site. The care plan also directed the nurse to monitor the shunt every shift for the presence of bruit and thrill and if there was an absence of bruit to report to the dialysis physician, as it was a sign of occlusion. The treatment records were reviewed for July, August and September of 2016 and there was no documentation that the shunt site was being monitored for redness, bleeding, pain, swelling or the presence of bruit and thrill. On 9/15/16, at 12:58 p.m. R70 stated that the nurses only observe the site every two to three days. On 9/15/16, at 1:07 p.m. licensed practical nurse (LPN)-A stated the monitoring should be documented in the treatment record. LPN-A further stated that the monitoring for patency by checking for the bruit and thrill was done by the registered nurse (RN) as she was not trained to	F 282	treatment sheet reviewed and revised on 9/15/16. Corresponding updates have been made to care assignment sheets and communicated to the resident. Education has been provided for licensed nursing staff members regarding monitoring of dialysis access sites and dialysis access site emergencies on 10/13/16. For residents on dialysis who may be affected by this practice, an audit on dialysis care plans was completed on 10/12/16. Upon this review, care plan revisions and licensed nursing staff education will be implemented if indicated by 10/13/16. The policy for dialysis comprehensive care plans has been reviewed and revised by the interdisciplinary team. Licensed Nursing Staff members were trained as it relates to their respective roles and responsibilities regarding dialysis access site and dialysis access emergencies policy and procedures on 10/13/16. Weekly dialysis access site monitoring audits will be conducted weekly for four weeks, monthly for three months, and randomly thereafter to ensure compliance with results reported to QA Committee for review and further recommendations. For resident #R7 care plan and care assignment sheet reviewed and revised on 9/15/16. Corresponding updates have been made to care assignment sheets and communicated to the designated decision maker. New oral assessment completed on 10/7/16. For other dependent residents affected by this practice, an audit on oral care plans and	

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F 282	Continued From page 15 do it. On 9/15/16, at 1:21 p.m. RN-B stated the the floor charge nurse was responsible for monitoring the shunt site for bleeding, infection and the presence of the bruit and thrill. RN-B stated the charge nurse is either a LPN or RN. RN-B further stated that it should be documented in the treatment record and monitored every shift. Upon review of the residents record RN-B stated that the treatment order was discontinued when the resident was hospitalized in 4/16 and it was never re-initiated. RN-B further stated she could not be sure the site was being properly monitored without documentation. On 9/15/16, at 2:42 p.m. the director of nursing (DON) stated she expected the care plan be followed. R7's care plan dated 5/27/16, identified R7 was at risk for poor oral hygiene and had own teeth. The careplan indicated R7 was to receive "A1 [assist of one] with oral cares BID [twice a day] and prn [as needed]. Oral swabs after meals." R7's undated care list instructed staff to provide oral cares with assist of one. It also identifies that R7 is to receive assist to "SWAB mouth after every meal." On 9/14/16, at 8:04 a.m. nursing assistant (NA)-B was observed during provision of morning cares for R7. R7 did not receive oral cares. NA-B stated that she "completely forgot" to complete oral hygiene. "I should have done that before bringing [R7] out to breakfast." On 9/15/16, at 2:27 p.m., registered nurse (RN)-B stated R7 "should be receiving oral care BID with	F 282	care assignment sheets was completed on 10/7/16. Upon this review care plan revisions and/or staff education will be implemented if indicated by 10/18/16. The policy for oral cares has been reviewed by the interdisciplinary team. Direct Care Staff members have been trained as it relates to their respective roles and responsibilities regarding the oral care policy/procedure on 10/17/16. Oral care audits will be conducted weekly for one month, monthly three months and randomly thereafter with results reported to QA Committee for review and further recommendation. 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 of Correction: 10/18/16	

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F 282	Continued From page 16 morning and bedtime cares." RN-B stated that she would expect R7 would be taken in to the bathroom and oral cares completed. A facility Care Plans policy dated 10/15, identified the resident care plan was used to ensure residents received, "The appropriate care required to maintain or attain the resident's highest level of practicable function possible."	F 282		
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 monitor the shunt site for bleeding, infection and patency for 1 of 1 residents (R70) reviewed for dialysis. Findings include: R70's quarterly Minimum Data Set (MDS) dated 8/10/16, indicated R70 had moderate cognitive impairments. The Resident Face Sheet dated 8/4/16, included diagnoses of end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitius with diabetic chronic kidney disease.	F 309	F309 It is the policy of St. Clare Living Community to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment and plan of care. For resident #R70 care plan and treatment sheet reviewed and revised on 9/15/16. Corresponding updates have been made to care assignment sheets and communicated to the resident. Education has been provided for licensed	10/13/16

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F 309	Continued From page 17 R70's care plan dated 3/8/16, indicated R70's shunt was in her right arm. R70 received dialysis Monday, Wednesday and Friday and was at risk for bleeding due to heparin use at dialysis. The care plan directed the nurse to monitor the access site for redness, bleeding, pain and swelling, however did not direct staff on how frequently to monitor the site. The care plan also directed the nurse to monitor the shunt every shift for the presence of bruit and thrill and if there was an absence of bruit to report to dialysis physician, as it is a sign of occlusion. The treatment records were reviewed and there was no documentation that the shunt site was being monitored for redness, bleeding, pain, swelling or the presence of bruit and thrill. On 9/15/16, at 12:58 p.m. R70 stated that she had a graft site in her right arm. R70 pulled of her sweater to reveal the graft site. The area was free from bleeding, swelling and signs and symptoms of infection. R70 stated that the nurses observed the site every two to three days. On 9/15/16, at 1:07 p.m. licensed practical nurse (LPN)-A stated she looked at the shunt site daily when she worked to observe for bleeding and redness, but currently there was not anywhere to document it. LPN-A stated it should be documented in the treatment record. LPN-A further stated the monitoring for patency by checking for the bruit and thrill was done by the registered nurse (RN) as she was not trained to do it. On 9/15/16, at 1:21 p.m. RN-B stated the the floor charge nurse was responsible for monitoring the shunt site for bleeding, infection and for the	F 309	nursing staff members regarding monitoring of dialysis access sites and dialysis access site emergencies on 10/13/16. For residents on dialysis who may be affected by this practice, an audit on dialysis care plans was completed on 10/12/16. Upon this review, care plan revisions and licensed nursing staff education will be implemented if indicated by 10/18/16. The policy for dialysis comprehensive care plans has been reviewed and revised by the interdisciplinary team. Licensed Nursing staff members were trained as it relates to their respective roles and responsibilities regarding dialysis access site and dialysis access emergencies policy and procedures on 10/13/16. Weekly dialysis access site monitoring audits will be conducted weekly for four weeks, monthly for three months, and randomly thereafter to ensure compliance with results reported to QA Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance. Date of Correction: 10/13/16.	

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F 309	Continued From page 18 presence of bruit and thrill. RN-B stated the charge nurse is either a LPN or RN and capable of assessing the area. RN-B further stated that it should be documented in the treatment record and monitored every shift. Upon review of R70's record RN-B stated that the treatment order was discontinued when the resident was hospitalized in 4/16 and was never re-initiated. RN-B further stated she could not be sure the site was being properly monitored without documentation. On 9/15/16, at 2:42 p.m. the director of nursing (DON) stated if there was no treatment sheet staff would not know when and what to monitor with the dialysis site. A policy on caring for dialysis residents was requested and not received.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to maximize independence with eating for 1 of 1 residents (R52) reviewed with a change in ability to feed themselves. Findings include: R52's quarterly Minimum Data Set (MDS) dated	F 311	F311 It is the policy of St. Clare Living Community to provide care and services by qualified persons In accordance with each resident□s written plan of care. For resident□s # R52 the care plan reviewed and revised on 10/7/16. Corresponding updates have been made to resident□s individual meal tray card and communicated to the residents and/or	10/18/16

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F 311	Continued From page 19 4/28/16, identified R52 had moderate cognitive impairment and required only supervision with eating. R52's most recent quarterly MDS dated 7/21/16, identified R52 continued to have cognitive impairment, however now required extensive assistance from staff with eating. R52's Oral Cavity Assessment dated 7/20/16, identified several questions to be assessed including, "Loss of Function - Does resident exhibit any physical decline in ADL abilities, such as ability to perform oral care, ability to feed self, etc." The assessment questions were answered with, "No." R52's Mini-Nutritional Assessment dated 7/18/16, identified R52 consumed three full meals a day. R52 was identified as able to feed himself, "with some difficulty". Staff noted, "Independent at meals with extensive assist at meals PRN [as needed]." On 9/12/16, at 10:41 a.m. R52 was seated in the main dining room at a table with several other residents. R52 was served french toast with ground meat. Nursing assistant (NA)-D cut up R52's french toast and went to the opposite side of the table to serve another resident. R52 sat at the table with his hands in his lap. At 10:45 a.m. NA-D stated, "[R52], aren't you hungry?" R52 picked up a regular fork using his right hand and took a bite of the cut up french toast, however dropped his fork on the edge of the table causing it to land on his lap. NA-D walked over to R52, picked up his fork and placed it back on his plate. R52 picked up the fork and started to eat the ground meat. At 10:55 a.m. R52 again dropped the fork on his lap, and NA-G picked up the fork placing it back on his plate. R52 picked up a	F 311	designated decision maker. Education to NA/R's and Wellness staff members regarding adaptive equipment at meals and nutritional risks to maintain stable weight on 10/17/16. For residents who require assist with meals and adaptive equipment who are affected by this progress, an audit on nutritional risk care plans and continuing education of staff responsible for care was completed on 10/8/16. Upon this review care plan revisions and/or staff education implemented if indicated by 10/11/16. The policy for adaptive feeding equipment has been reviewed and revised by the interdisciplinary team. NA/R's and Wellness staff members were trained as it relates to their respective roles and responsibilities regarding the adaptive equipment policy and procedure on 10/17/16. Meal service audits will be conducted three times per week for 30 days, then weekly for 30 days, then monthly for three months and randomly thereafter. Results will be reported to QA 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 of Correction: 10/18/16	

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F 311	Continued From page 20	F 311		

butter knife and attempted to eat the cut up pieces of his french toast before setting it back on the table. NA-G then assisted R52 with eating for the remainder of the meal.

On 9/13/16, at 5:01 p.m. R52 was seated in the main dining room and had been served a plate of cheese casserole and egg salad sandwich. NA-E was seated with R52 and assisted him with eating by placing food on the utensil, then provided it to R52 who lifted the utensil from the plate to his mouth and took the bite of food. At 5:04 p.m. NA-H wheeled a stool over, sat next to R52, and placed a straw in his milk. R52 continued to take several bites of casserole on his own. NA-H began to pile food up in the middle of R52's plate. R52 continued to take bites on his own using the spoon for the remainder of the meal.

On 9/14/16, at 1:00 p.m. NA-D stated R52's eating ability, "kinda varies on the day" and staff will at times have to help him. NA-D stated R52 used to be independent with eating, however lately has been requiring more assistance adding she had, "noticed the decrease in ability to do things on his own." NA-D stated she reported these changes to the nurses and, "They've been watching."

On 9/15/16, at 9:46 a.m. registered nurse (RN)-B stated she was unaware R52 had sustained a change in his ability to feed himself. RN-B reviewed R52's medical record and stated although there was a change identified on the MDS, there had been no comprehensive reassessment of R52's eating ability completed by nursing or therapy. Further, RN-B stated R52 should have been reassessed to determine if any further interventions could have improved his

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F 311	Continued From page 21 ability to feed himself, "to maintain his highest level of independence." A facility policy on reassessment with change in condition/Activities of Daily Living ability was requested, but none was provided.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene for 1 of 1 dependent residents (R7) observed for activities of daily living (ADL's). R7's annual minimum data set (MDS) of 8/12/16, identified R7 had severe cognitive impairment and was dependent on staff for complete assistance with all aspects of activities of daily living including grooming. R7's MDS did not identify behavior problems, including rejection of cares. R7's medical diagnoses included Alzheimer's disease, Parkinson's disease, and a cerebral vascular accident (stroke) On 9/13/16, at 5:58 p.m. family member (FM)-L was observed pushing R7 into the room. FM-L stated that they were going in to the room to brush R7's teeth. FM-L stated they routinely provided oral cares (brushing and flossing) to R7	F 312	F312 It is the policy of St. Clare Living Community to provide care and services by qualified persons In accordance with each resident□s written plan of care. For resident #R7 care plan and care assignment sheet reviewed and revised on 9/15/16. Corresponding updates have been made to care assignment sheets and communicated to the designated decision maker. New oral assessment completed on 10/7/16. For other dependent residents affected by this practice, an audit on oral care plans and care assignment sheets was completed on 10/7/16. Upon this review care plan revisions and/or staff education will be implemented if indicated by 10/18/16. The policy for oral cares has been reviewed by the interdisciplinary team.	10/18/16

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F 312	Continued From page 22 when they visited, on a nearly daily basis. FM-L stated R7 was followed routinely by the dentist, with known cavities present, but was unable to have dental restoration done due to a neurological disorder which would not allow placement of a drill in R7's mouth. FM-L stated "[R7] always worked extra hours so us kids could go to the dentist." FM-L further stated R7's natural teeth had been maintained. FM-L stated "I know that it is important to [R7] so I do it when I am here." FM-L further stated oral hygiene was completed by staff "usually, but I know how it is. Sometimes there is just not time." FM-L stated they [staff] will use swabs. FM-L was observed performing oral hygiene. R7 was observed to accept oral hygiene without demonstration of resistance or signs of discomfort, such as grimacing, holding mouth shut, or verbalization of discomfort. On 9/14/16, at 8:04 a.m. nursing assistant (NA)-B was observed during provision of morning cares, which included washing and drying of face and hands, performance of incontinence care, and assisting R7 to dress. NA-B transferred R7 into the wheelchair assisted by NA-C, and completed morning cares with the application of glasses and combing hair. R7 was assisted to the dining room for breakfast meal at 8:26 a.m. NA-B then returned to the room to remove garbage and linens. NA-B stated that she "completely forgot" to complete oral hygiene and stated "I should have done that before bringing [R7] out to breakfast. R7's care plan dated 5/27/16, identified R7 had the problem of being at risk for poor oral hygiene and R7 had their own teeth. The careplan identified R7 was to receive "A1 [assist of one] with oral cares BID [twice a day] and prn [as	F 312	Direct Care Staff members have been trained as it relates to their respective roles and responsibilities regarding the oral care policy/procedure on 10/18/16. Oral care audits will be conducted weekly for one month, monthly three months and randomly thereafter with results reported to QA Committee for review and further recommendation. 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 of Correction: 10/18/16	

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F 312	Continued From page 23 needed]. Oral swabs after meals." R7's undated care list instructed staff to provide oral cares with assist of one. On 9/15/16, at 2:27 p.m., registered nurse (RN)-B stated R7 "should be receiving oral care BID with morning and bedtime cares." RN-B stated that routine morning care included residents being assisted to wash and dry, incontinence care provided, dressed and provided with transfer assist up into wheelchair. RN-B stated that she would expect R7 would be taken in to the bathroom and oral cares completed. A policy for provision of oral cares was requested but not provided.	F 312		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		10/13/16

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F 322	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to check placement of a gastrostomy tube (g-tube) prior to the administration of medications for 1 of 1 residents (R42) reviewed for medication administration. Findings include: R42's admission Minimum Data Set dated 8/10/16, indicated R42 was cognitively intact. The MDS also identified R42 had a feeding tube and had suctioning treatments. R42's Resident Face Sheet identified R42 had a history of pneumonitis due to inhalation of food and vomit. R42's care plan dated 8/25/16, indicated R42 was NPO (nothing by mouth) a had g-tube for medication administration. On 9/13/16, at 7:00 p.m. registered nurse (RN)-C was observed to dispense Trazodone (antidepressant) 50 mg 1/2 tablet and Celexa (antidepressant) 10mg 1 tablet. RN-C crushed the medications separately and placed them separately into 30 cubic centimeters (cc) of water to dissolve. At 7:03 p.m. RN-C entered R42's room with the medications, went to the bathroom, washed her hands and put on non-sterile gloves. RN-C placed a towel under R42's g-tube, opened the tube and placed a syringe into the tube. RN-C poured 30 cc's of water down the tube, then a	F 322	F322 It is the policy of St. Clare Living Community to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in the accordance with the comprehensive assessment and plan of care. For resident # R42 Education has been provided for licensed staff members regarding checking nasogastric tube placement policy on 10/11/16. No other residents are affected by this practice. The policy for checking nasogastric tube placement has been reviewed by the interdisciplinary team. Licensed staff members were trained as it relates to their respective roles and responsibilities regarding checking nasogastric tube placement policy and procedure on 10/11/16. Checking nasogastric tube placement audits will be conducted weekly for four weeks, then monthly for 3 months and randomly thereafter to ensure compliance with results reported to the QA Committee for review and further recommendations. The Director of Nursing or designee will be responsible for compliance.	

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F 322	Continued From page 25 medication, followed by another 30 cc's of water, the other medication followed by 30 cc's more of water. RN-C did not check the placement of the g-tube prior to the administration of the water and medications. On 9/13/16, at 7:18 p.m. RN-C stated she had checked the g-tube placement earlier in the shift prior to administering earlier scheduled medications, but had not checked the g-tube for placement before administering the Trazodone or Celexa. On 9/13/16, at 7:34 p.m. RN-C stated that after reviewing the facility policy she should have checked for accurate placement of the g-tube prior to administering her medications. On 9/14/16, at 12:43 p.m. R42 stated she usually watched staff administer her medications and stated the nurse generally checks placement prior to administrating medications, but not every time. On 9/15/16, at 2:39 p.m. the director of nursing (DON) stated she expected placement of a g-tube be checked every time prior to medication administration. The undated facility policy Gastrostomy Intermittent Tube Feeding/ Medication, directed staff to check/measure for residual gastric contents. Pour 30 cc's of room temperature water into the syringe to check for patency then administer medications one at a time.	F 322	Date of Correction: 10/13/16	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment	F 369		10/18/16

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F 369	Continued From page 26 and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment to maximize the ability to feed themselves for 1 of 2 residents (R52) reviewed for activities of daily living (ADLs). Findings include: R52's quarterly Minimum Data Set (MDS) dated 7/21/16, identified R52 had severe cognitive impairment, and required extensive assistance with eating. During observation of the brunch meal on 9/12/16, at 10:25 a.m. R52 was seated at a table in the main dining room. R52 had a white menu slip placed next to him on the table which identified his name, along with bolded print stating, "GIVE LIP PLATE @ [at] MEALS." At 10:41 a.m., R52 was served a plate of french toast with ground meat on a non-lipped, regular ceramic plate. Nursing assistant (NA)-D cut up R52's french toast and left the table to serve another resident. R52 picked up his fork and moved the ground meat around his plate, at times having the meat on the far edge of plate. R52's Mini-Nutritional Assessment dated 7/18/16, identified R52, "Feeds Self With Some Difficulty [sic]," and used adaptive equipment at meals, "Lipped plate at meals." R52's care plan dated 8/3/16, identified R52 was at, "Nutritional risk," and directed staff to use,	F 369	F369 It is the policy of St. Clare Living Community to provide care and services by qualified persons In accordance with each resident□s written plan of care. For resident□s # R52 the care plan reviewed and revised on 10/7/16. Corresponding updates have been made to resident□s individual meal tray card and communicated to the residents and/or designated decision maker. Education to NA/R's and Wellness staff members regarding adaptive equipment at meals and nutritional risks to maintain stable weight on 10/17/16. For residents who require assist with meals and adaptive equipment who are affected by this progress, an audit on nutritional risk care plans and continuing education of staff responsible for care was completed on 10/8/16. Upon this review care plan revisions and/or staff education implemented if indicated by 10/11/16. The policy for adaptive feeding equipment has been reviewed and revised by the interdisciplinary team. NA/R Wellness Staff members were trained as it relates to their respective roles and responsibilities regarding the adaptive equipment policy and procedure on 10/18/16. Meal service audits will be conducted three times per week for 30 days, then weekly for 30 days, then monthly for three	

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F 369	Continued From page 27 "Adaptive equipment at meals," to help R52, "Maintain stable weight." On 9/13/16, at 5:01 p.m. R52 was seated in the main dining room. R52 had been served cheese casserole and an egg salad sandwich on a regular, non-lipped ceramic plate. R52 had a white menu slip placed on the table next to him which still identified, "GIVE LIP PLATE @ MEALS." R52 attempted to take bites of casserole using a regular spoon, at times spilling casserole onto the table and placemat. On 9/14/16, at 11:38 a.m. NA-F stated R52, "struggles sometimes" to get the food placed on his utensils when eating adding she was unaware R52 should be using a lipped plate with meals. NA-F reviewed R52's white menu card and stated, "It says on his diet card he is supposed to." Further, NA-F stated she worked with R52 the week prior and he had not been served using a lipped plate, "He didn't have a lipped plate last week." On 9/14/16, at 1:00 p.m. NA-D stated R52 was, "generally" served using a regular plate at meals. NA-D stated she was unaware what type of plate R52 should be using at meals adding she has observed him before to eat and spill food off the sides of the plate. On 9/14/16, at 1:53 p.m. registered nurse (RN)-B stated R52 was, "supposed to have a lipped plate," provided at meals to help him eat on his own and, "keep his food on his fork." An undated facility Adaptive Feeding Equipment policy identified, "Adaptive feeding equipment will allow residents to be more self sufficient when	F 369	months and randomly thereafter. Results will be reported to QA 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 of Correction: 10/18/16	

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F 369	Continued From page 28 eating." The policy directed, "Licensed nursing staff and therapy will assess the resident for the need for adaptive feeding equipment," and, "Nursing staff together with Dietary, will see that the devices are available during meal time."	F 369		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate dental care and services for 1 of 2 residents (R34) reviewed for dental care. Findings include: R34's quarterly Minimum Data Set (MDS) dated 9/1/16, identified that cognitive assessment was not completed as resident was rarely/never understood. It also identified that R34 required limited assistance of one to complete personal grooming. On 9/12/16, at 3:07 p.m., R34 was noted to be edentulous (without dentures and teeth). R34	F 412	F412 It is the policy of St. Clare Living Community to provide routine and emergency in accordance with each resident□s plan of care. For resident #R34 care plan reviewed and revised on 10/10/16. Corresponding updates have been made to care assignment sheet and communicated to designated decision maker. Education has been provided for Licensed Nursing and NA/R's staff members regarding dental services and emergency dental services on 10/13/16 & 10/17/16. For all residents with dentures who may be affected by this practice an audit for ill	10/25/16

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F 412	Continued From page 29 stated that their dentures were in the nightstand and that they would wear them "sometimes." R34's lower denture was noted to be in a dry denture cup in the nightstand drawer. On 9/13/16, at 5:57 p.m.. R34 was sitting in the dining room. R34 was not wearing dentures. R34 stated he had completed his meal. R34 had a dental exam on 10/12/15, was noted to be edentulous, and had presented with a broken upper dental plate which required repair. The dental note identified R34 stated he "eats fine." The documentation indicated that a treatment plan was sent to family to decide if they wished to move forward with plan to repair upper plate. On 9/14/16, at 11:05 a.m. family member (FM)-K stated R34 had dentures previously but they required repair. FM-K stated the nurses were working on this, but that it "takes a long time." FM-K stated they desired R34's upper plate be repaired or replaced and felt that it may help with R34's eating and intake. R34's care plan, most recently reviewed on 4/1/16, directed staff to monitor for ill-fitting dentures and problems chewing. The interventions identified that "Dentures broken-see dentist dictation 10/1/15." R34's care plan also identified R34 was at nutritional risk. On 9/15/16, at 1:55 p.m., registered nurse (RN)-B stated a resident's dental status was addressed as needed, or when concerns arose. RN-B stated R34's dental status was most recently addressed with the MDS dated 8/26/16, which identified R34's dentures were broken, but did indicate any further interventions. RN-B stated this was	F 412	fitting, broken, or missing dentures was completed on 10/25/16. The policy for dental services and emergency dental services had been reviewed by the interdisciplinary team. Licensed Nursing and NA/R Staff members were trained as it relates to their respective roles and responsibilities regarding dental services and emergency dental services policy and procedure on 10/13/16. Resident denture audits will be completed weekly for one month, monthly for three months, randomly thereafter to ensure compliance with results to the QA Committee for review and further recommendations. Date of correction: 10/25/16	

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F 412	Continued From page 30 normally addressed at care conferences. However this was not addressed with recent conference, as FM-K "didn't want anything to do with them [R34's dentures]." RN-B stated she had not addressed R34's dentures or oral status with FM-K.	F 412		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		10/18/16

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F 441	Continued From page 31 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow proper infection control practices for 2 of 4 residents (R1 and R19) observed. Findings include: R19's annual Minimum Data Set (MDS) dated 8/12/16, indicated R19's cognition was moderately impaired. The annual MDS gave diagnosis of cerebral vascular accident (CVA). On 9/14/16, at 7:21 a.m. of nursing assistant (NA)-D was wearing gloves. NA-D assisted R19 to sit on the edge of the bed, placed a harness for the mechanical stand lift around R19, secured it to the mechanical stand lift, and R19 was raised to a standing position. NA-D removed R19's soiled incontinent product, got a wet cloth, wiped the rectal area and put the soiled cloth on the floor. NA-D got another wet cloth, wiped R19's perineal area and placed the soiled cloth on the floor. NA-D dried the rectal area and perineal area and placed the towel on the floor. NA-D removed the gloves and used hand sanitizer. NA-D donned gloves, put a clean brief on R19 and pulled up the pants. NA-D removed the gloves. NA-D moved a wheelchair to the mechanical stand lift and R19 was lowered into	F 441	F441 It is the policy of St. Clare Living Community to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. For residents # R1 and #R19 an audit was completed on 10/12/16. Policy for handling of soiled linens has been reviewed. Direct Care Staff members were trained as it relates to their respective roles and responsibilities regarding the handling of soiled linen policy and procedures on 10/18/16. Handling of soiled linen audits will be conducted weekly for four weeks, then monthly for three months, and randomly thereafter with results reported to QA 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 of correction: 10/18/16	

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 _____	09/15/2016

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 441	Continued From page 32 the wheelchair. The mechanical stand lift harness was removed and the lift moved away from R19. NA-D finished assisting R19 with morning cares. At 7:42 a.m. NA-D put gloves on and picked up the soiled linen from the floor, went to the soiled utility room, put the soiled linen in the receptacle and then washed hands. On 9/14/16, at 7:44 a.m. with NA-D stated "Yes I put the soiled linen on the floor. I do not want to put it on the bed or table." On 9/14/16, at 1:38 p.m. R1 was resting in bed with eyes closed. A bagged up soiled brief was sitting on the bedside table next to a pillow. Upon interview on 9/14/16, at 1:39 p.m. NA-D stated R1 was assisted to bed at noon and R1's brief was changed at that time. NA-D stated R1 was unable to use a call light. On 9/14/16, 2:00 p.m., while standing outside R1's room, the director of nurses (DON) stated that soiled briefs and linens should be removed from a resident's room when the staff have completed cares. The DON removed the bag from the bedside table and put it in the soiled utility room receptacle. On 9/15/16, at 9:39 a.m. registered nurse (RN)-D stated soiled linens should not go on the floor. RN-D stated staff should have used a plastic bag or laundry bag to set the soiled linen on or in but not on the floor. A policy was requested for handling soiled linens and briefs and none was provided.	F 441		
F 465	483.70(h)	F 465		10/25/16

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F 465 SS=E	Continued From page 33 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 interview, observation, and document review the facility failed to ensure resident care equipment was kept in a clean and sanitary condition for 7 residents (R1, R7, R18, R27, R53, R54, and R72) who utilized a mechanical total lift and for 7 residents (R11, R19, R33, R44, R52, R69, and R73) who utilized a mechanical standing lift. The facility failed to ensure resident's living spaces were kept in good repair for 6 of 30 resident's rooms observed to have damaged walls. The facility also failed to ensure the resident's living space vent areas were free from dust particles in 6 of 30 resident's rooms. Findings include: On 9/14/16, at 1:28 p.m., it was noted that mechanical standing lift 5 had white tape on the controller and the bottom of the mechanical standing lift to the battery area. The tape was soiled with dirt, peeling, and worn through to expose a gray piece of styrofoam. The padding on the arms of the mechanical stand lift was frayed on the ends. Mechanical total lift 8 had gray styrofoam and white tape around the base of the lift. Mechanical total lift 7 had gray styrofoam and	F 465	F465: Safe/Functional/Sanitary Environment St. Clare provides a safe and functional, sanitary and comfortable environment for residents, staff and the public. The mechanical lifts and Sit-to Stand lift are on a monthly cleaning and maintenance schedule. Lift # 5: This lift is the only lift that does not have removable batteries. Instead it has a transformer that you plug in to recharge the permanently mounted batteries. The tape holding the transformer on was removed, the lift was thoroughly cleaned and the transformer was re-attached to the lift using a cleanable zip strap. The padding on the arms has been replaced with new vinyl padding. Lift # 8: The white tape and gray foam has been removed and replaced with a custom padded vinyl sleeve, which is a cleanable surface. Lift #7: The white tape and gray foam has	

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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 34 white tape around the base of the lift and the padding on the boom arm was ripped open and frayed. On 9/15/16, at 1:00 p.m. during the environmental tour, mechanical standing lift 9 was observed to have open frayed areas on the padding on the arm of the lift. Mechanical total lift 4 had padding that was frayed by the harness hooks. Mechanical stand lift 3 had padding by the arm lifts that was frayed on both sides. Mechanical stand lift 2 had black electrical tape around a controller plug. The administrator stated that it was not acceptable to be held together with black electrical tape. Mechanical stand lift 1 had cracked padding on the arm of the lift. On 9/15/16, at 1:08 p.m. the administrator stated the lower box at the bottom and the controller was taped to keep the wires in place because staff was not careful when using the equipment. The administrator did not want the wires coming out of the box. The administrator also stated the tape was an added safety procedure so the wires would not pull out. The administrator stated the taped areas were not a cleanable surface nor was the frayed padded area on the lifts. The administrator was not aware how long the tape and gray styrofoam had been on mechanical lifts. The administrator stated the padding on the boom arms of the mechanical total lifts were frayed and there was a schedule to replace them.	F 465	been removed and replaced with a custom padded vinyl sleeve, which is a cleanable surface. The padding on the boom arm was replaced with new vinyl padding. Lift # 9: The frayed padding was replaced with new vinyl padding. Lift #4: The padding on the harness hooks was replaced with new vinyl padding. Lift #3: The padding on the lift arms has been replaced with new vinyl padding Lift #2: The black electrical tape was removed and the controller was replaced. Lift #1: The cracked padding on the arm was replaced. We also replace the controller. The on-going maintenance schedule form has been changed to include a space to record when the protective paddings are replaced. Room 105: The dings in the sheet rock has been repaired and re-painted. Room 139: The sheet rock was damaged by the resident recliner. The wall has been repaired and repainted. Room 140: The sheet rock was damaged by the resident bed. The wall has been repaired and repainted.	

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F 465	Continued From page 35 A cleaning and maintenance of mechanical lifts form dated 1/16, through 9/16, lacked documentation that the safety pads on the mechanical lifts were replaced. A facility policy Cleaning and Disinfection of Resident Care Items and Equipment dated 7/14, indicated reusable items were cleaned and disinfected or sterilized between residents. The policy also revealed durable medical equipment must be cleaned and disinfected before reuse by another resident. On 9/12/16, at 10:42 a.m. revealed room 105 had multiple holes in the sheet rock behind the recliner. Room 139 had scrapes measuring approximately three inches by one inch on several areas behind the recliner and a scrape at the head of the bed approximately one inch by four inches. Room 140 had a large scrape measuring approximately twelve inches with an area gouged out measuring one and half inches by nine inches long, and looked to go through almost the full thickness of sheet rock. Room 146 had exposed sheet rock in several spots on the wall behind the recliner. Room 156 had a baseball sized hole that exposed the sheet rock. On 9/15/16, at 1:29 p.m., the administrator stated there were rooms with exposed sheetrock. The administrator stated the process is for housekeeping to report to maintenance and then the the facilty will work on the holes and scrapes in the sheet rock. A review of the maintenance repair request book dated 9/16, did not indicate scrapes in the sheet rock or holes on the walls had been reported or that they were in need of repair.	F 465	Room 146: The sheet rock was damaged by the resident recliner. The wall has been repaired and repainted. Room 156: The sheet was repaired and repainted. Rooms 111,135,149,155,156 vent in the bathroom were thoroughly cleaned. The facility environmental service staff met on Wednesday 10/12/16 to discuss the issue with the vents. Expectations were established. Audits of room cleanliness, Wall repair, and Lift condition will be conducted by the administrator weekly for four weeks, then monthly thereafter. Audit results will be reported to the QA/QI Committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Person Responsible: The administrator will be responsible for monitoring for on-going compliance. Date of Correction: 10/25/16	

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	245291	A. BUILDING _____ B. WING _____	09/15/2016

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F 465	Continued From page 36 On 9/12/16, at 10:38 a.m. rooms 111, 135, 149, 155, and 156 were observed to have bathroom vents that were visibly dusty. On 9/12/16, at 10:36 a.m. revealed room 105's heat register was visibly dusty. On 9/15/16, 1:20 p.m., the administrator stated the residents rooms should be cleaned daily. The administrator stated rooms are deep cleaned on a monthly basis and there was a schedule for the deep cleaning. The administrator verified the vents were visibly dusty. A review of the housekeeping thorough cleaning schedule dated 8/18/16, to 9/14/16, indicated room 105 was thoroughly cleaned on 9/1/16, room 111 was thoroughly cleaned on 9/2/16, room 135 was thoroughly cleaned on 8/23/16, room 155 was thoroughly cleaned on 9/14/16, and room 156 was thoroughly cleaned on 8/18/16. The facility policy Thorough Cleaning Room after Resident Leaves dated 3/26/13, directed staff to dust mop and wet mop the entire room.	F 465		
F 469 SS=C	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 469	F469 Maintains effect pest control	10/25/16

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F 469	Continued From page 37 review, the facility failed to implement an effective pest control program to control flies in the facility. This had potential to affect all resident, staff and visitors in the facility. Findings include: On 9/15/16, at 12:21 p.m. family member (FM)-K stated the facility had a pest control problem, "The damn flies are all over." FM-K stated he would sit with his spouse at meals and flies were constantly landing on the plates and food, "like crazy." FM-K had been told by staff he could not have a fly swatter present in the dining room because of, "state law". FM-K added, having so many flies was, "an unhealthy annoyance" for the residents and visitors. Further, during the interview FM-K stopped and pointed to a fly buzzing around his head, "There's another one right there!" R103's quarterly Minimum Data Set (MDS) dated 8/4/16, identified R103 had moderate cognitive impairment. On 9/15/16, at 12:58 p.m. R103 stated she noticed flies buzzing around her plate during meal times, "everyday," and this occurred at nearly every meal. R103 stated she didn't, "think its very nice," having flies around her food at meals. She had to constantly, "flush them off to go away [swat at them]." On 9/15/16, at 1:02 p.m. nursing assistant (NA)-A stated she had noticed a, "little bit" of a problem with flies in the dining room(s) during meal service. NA-A stated she had heard residents complaining about it before, however she was unaware what was being done about it, "I'm not	F 469	program. The facility does maintain an effective pest control program. Our contract exterminator does monthly service and also comes out when additional help is needed (seasonal issues). During the survey, SA interviewed residents, family members and staff. Through these interviews it was discussed that there was an issue with flies coming into the main dining room. The administrator contacted our contract exterminator. He discussed various options that could control the issue. The facility has purchased and installed two UV fixtures designed to control flies in the building. The facility reviewed the pest control policy and education of the staff on the process of reporting pest issues was discussed at the All Staff Meeting on Tuesday, October 18, 2016. The Wellness Director will audit for compliance by interviewing 5 residents and Staff members per week for four weeks to ensure that the pest control issue has be successfully corrected. Audit results will be reported to the QA/QI Committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.	

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F 469	Continued From page 38 really sure." On 9/15/16, at 1:19 p.m. trained medication aide (TMA)-A stated residents had complained about the flies in the dining room before because they had been, "getting around plates and what not." TMA-A stated she was unaware what was being done to address the flies. TMA-A stated she had not reported the concern to anyone in management, however it was often discussed, "just back and forth amongst us fellow employees." Further, TMA-A stated the flies were, "an annoyance," and at times would be so bad staff had to swat them away, "through the [entire] meal." On 9/15/16, at 2:07 p.m. the administrator stated he was unaware the facility had any concerns with flies being present during meals in the dining room. "I hadn't heard of any flies." The administrator stated he expected staff to notify him of concerns like pests and flies, adding nothing was being done about the flies because he didn't know it was a concern. "Nobody told me about it." A facility Pest Control policy dated 1/14, identified the administrator was responsible for, "Establishing a continuous pest control program," and added, "Effective measures must be taken to prevent the entrance, breeding or presence of rodents, flies, cockroaches and other vermin or insects on the premises."	F 469	The administrator will be responsible for monitoring the ongoing compliance of this requirement. Date of Correction: 10/25/16 Plan of Correction Disclaimer Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance	

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	245291	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/15/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Clare Living Community of Mora was found not in 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/07/2016

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 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St. Clare Living Community of Mora is a 1-story building with small partial basement. The original building was constructed in 1969 and additions constructed in 1999. The 1969 building is of type II(111) construction and the 1999 building is type V(111) construction. To the north a single story type V(111) assisted living facility also adjoins and is separated by 2 hour construction with a 90 minute rated, self closing door. Another addition of Type V(111) construction opened to the west in 2005, 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	K 000		

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K 000	Continued From page 2 and had a census of 57 at the time of the inspection. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 10 of 57 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, observations revealed that there is an opening around the conduit that is passing through the 2 hour fire barrier separating the care center from the assisted living building by the Administrator's above the fire rated door. This deficient condition was verified by the	K 011	K011 During survey with the state fire marshal it was observed that there were openings around the conduit passing through the firewall. The Administrator and the Environmental Service Director inspected all firewalls throughout the facility. Any openings around penetrations through fire walls were properly sealed using NFPA approved Fire Caulking. Person Responsible: The Administrator will be responsible to monitor on-going compliance with this code. Date of Completion: 10/13/16	10/13/16

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K 011	Continued From page 3 Administrator.	K 011		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of 3 smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19-3.7.3 and 8.3. This deficient practice could affect 40 of 57 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, observations revealed the following deficient conditions: 1. A non-fire rated expanding spray form material was used to fill all of the opening that are passing through the East Wing smoke barrier wall. 2. A non-fire rated expanding spray form material was used to fill all of the opening that are passing through the west Wing smoke barrier wall. This deficient condition was verified by the Administrator.	K 025	K025 During survey with the state fire marshal it was discovered that Non-Fire Rated Expanding Spray Foam materials were used to fill openings that passed through the East Wing Smoke Barrier. The Environmental Service Director removed all non-fire rated expanding foam from the east wing fire barrier and replaced it with NFPA approved Fire Caulking. Person Responsible for compliance: The administrator will be responsible for monitoring on-going compliance with this code. Date of Completion: 10/25/16	10/25/16

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 _____	**09/15/2016**

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
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain 2 of 3 smoke/fire barrier doors in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.7.5. This deficient practice could affect 40 of 57 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, observation revealed that the smoke barrier double doors located in the East and West Wings both swing in the same direction and they are not equipped with a door sequencing device. This deficient condition was verified by the Administrator.	K 027	K027 The facility has four wings protected by fire rated doors at the beginning of the smoke barrier. During the tour with the fire marshal it was observed that all fire barrier doors were functioning properly; however, 2 of the three doors were not equipped with a door sequencing device. The administrator ordered the door sequencing devices and the environmental service director installed the devices on 10/4/16. Person Responsible for compliance: The administrator will be responsible for monitoring on-going compliance with this code. Date of Completion: 10/4/16	10/4/16
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected	K 050		10/7/16

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 _____	**09/15/2016**

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
K 050	Continued From page 5 times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 4 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2, during the last 12-month period. This deficient practice could affect 57 of 57 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during the review of all available fire drill documentation and interview with the Administrator it was revealed that the facility did not conducted the evening fire drill at varying time by conducting 4 of 4 drills in the 3 p.m. hour. This deficient condition was verified by the Administrator.	K 050	K050 The facility conducts monthly fire drills that rotate between the day, evening, and night shifts. The drills are conducted on various days of the week and at different times of the month. These fire drills are scheduled on an annual basis for various days of the week, different week of the month and at varous times. However, it was noted in the documentation that the fire drills for the afternoon shift was consistently conducted at 3:00 PM regardless of the day of the week or the time of the month. The administrator reviewed the policies on fire drills with the safety committee. The drills going forward will be at different times throughout the afternoon shift. The next fire drill for afternoons is scheduled for the week of 10/3-10/7 and will be conducted at 7:00 PM. Person Responsible for compliance: The administrator will be responsible for monitoring on-going compliance with this code.	

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 _____	**09/15/2016**

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
K 050	Continued From page 6	K 050	Date of Correction: 10/7/16	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 57 of 57 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during a review of all available fire alarm maintenance/testing documentation for the last 12 months and an interview with the Administrator, it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by the Administrator.	K 052	K052 The facility conducts monthly fire drills to ensure staff preparedness and proper fire safety equipment operation. It has been St. Clare l s practice to engage our alarms system on the day and afternoon shifts. Then record the response time of our Digital Alarm Communicator Transmitter (DACT) to our Fire Department. It also has been our practice not to engage the alarms on the night shift because of the trauma that it could cause our resident. The drill is a silent drill with the staff going through the procedures without alarms. Unfortunately, that means the DACT system was only tested 8 out 12 fire drills. It should be noted that in those 8 drills the DACT system performed flawlessly. The administrator has updated the fire drill procedure to include testing the DACT system the morning after a fire drill on the night shift and record the DACT response time on the Fire Drill document. Person Responsible for compliance: The administrator will be responsible for	10/25/16

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	245291	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/15/2016**

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
K 052	Continued From page 7	K 052	monitoring on-going compliance with this code. 10/25/16	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code 1999 edition, section 7-3.2.1. This deficient practice could affect 57 of 57 residents,as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Administrator revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by the Administrator.	K 054	K054 St. Clare l s has its fire detection equipment inspected annually. This includes the alarm panel, smoke detectors, pull stations and the kitchen Annsul System. There is also a requirement to have a sensitivity test on the smoke detectors every two years. The last sensitivity test was beyond the required two years. The administrator has contacted our fire alarm contractor and scheduled a smoke detector sensitivity test for 10/19/16. The documentation of date and results of the test will be filed with our alarm system reports in our Life Safety Code Binder. Person Responsible for compliance: The administrator will be responsible for monitoring on-going compliance with this code. Date of Correction: 10/25/16	10/25/16
K 070 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 070		9/15/16

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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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K 070	Continued From page 8 Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of NFPA 101 Life Safety Code (00), Section 19.7.8. This deficient practice could affect 40 of 57 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, it was observed that there were an unapproved portable space heaters found at the receptionist desk at the main entry of the facility. The portable heater was located in a resident non-sleeping areas and the facility could not provide any documentation or policy regulating the use of portable space heating devices within the facility. This deficient condition was verified by the Administrator.	K 070	K070 The facility does not allow use of the portable space heating devices in the building. The portable space heating device tag in the citation was not in use at the time of this inspection and it was not the equipment of the facility. It was immediately removed from the building. The facility has not changed its policy; portable space heating devices are not to be used in the building. The administrator will monitor for on-going compliance with this code. Date of Correction: 9/15/16	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA	K 144		10/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 9 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4, 6-4.1, and 6-4.2.2. The deficient practice could affect 57 of 57 residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during the review of all available emergency generator maintenance documentation and an interview with the Administrator it was revealed that the facility did not have a letter of reliable service for their natural gas fuel supply from the fuel company. This deficient condition was verified by the Administrator.	K 144	K144 St. Clare[illegible]s has a natural gas operated emergency generator. It was noted during the Life Safety inspection that the facility does not have a Letter of Reliable Service to ensure a fuel source for the generator. The administrator has contacted Minnesota Energy who supplies natural gas to the facility and has requested a Letter of Reliable Service from them. The administrator will monitor for on-going compliance with this code. Date of Correction: 10/25/16	

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	245291	A. BUILDING **02 - VILLA HEALTH CARE CENTER** B. WING _____	**09/15/2016**

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 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey St. Clare Living Community of Mora, Building #2, the 2005 addition, was found not in substantial 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/07/2016

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 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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 57 at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 050		10/7/16

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 _____	**09/15/2016**

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K 050	Continued From page 2 conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 4 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.7.1.2, during the last 12-month period. This deficient practice could affect 57 of 57 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during the review of all available fire drill documentation and interview with the Administrator it was revealed that the facility did not conducted the evening fire drill at varying time by conducting 4 of 4 drills in the 3 p.m. hour. This deficient condition was verified by the Administrator.	K 050	K050 The facility conducts monthly fire drills that rotate between the day, evening, and night shifts. The drills are conducted on various days of the week and at different times of the month. These fire drills are scheduled on an annual basis for various days of the week, different week of the month and at various times. However, it was noted in the documentation that the fire drills for the afternoon shift was consistently conducted at 3:00 PM regardless of the day of the week or the time of the month. The administrator reviewed the policies on fire drills with the safety committee. The drills going forward will be at different times throughout the afternoon shift. The next fire drill for afternoons is scheduled for the week of 10/3-10/7 and will be conducted at 7:00 PM. Person Responsible for compliance: The administrator will be responsible for monitoring on-going compliance with this code.	

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K 050	Continued From page 3	K 050	Date of Correction: 10/7/16	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 57 of 57 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during a review of all available fire alarm maintenance/testing documentation for the last 12 months and an interview with the Administrator, it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT). This deficient condition was verified by the	K 052	K052 The facility conducts monthly fire drills to ensure staff preparedness and proper fire safety equipment operation. It has been St. Clare[illegible]s practice to engage our alarms system on the day and afternoon shifts. Then record the response time of our Digital Alarm Communicator Transmitter (DACT) to our Fire Department. It also has been our practice not to engage the alarms on the night shift because of the trauma that it could cause our resident. The drill is a silent drill with the staff going through the procedures without alarms. Unfortunately, that means the DACT system was only tested 8 out 12 fire drills. It should be noted that in those 8 drills the DACT system performed flawlessly. The administrator has updated the fire drill procedure to include testing the DACT system the morning after a fire drill on the night shift and record the DACT response time on the Fire Drill document. Person Responsible for compliance: The	10/25/16

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K 052	Continued From page 4 Administrator.	K 052	administrator will be responsible for monitoring on-going compliance with this code. 10/25/16	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code 1999 edition, section 7-3.2.1. This deficient practice could affect 57 of 57 residents,as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Administrator revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by the Administrator.	K 054	K054 St. Clare's has its fire detection equipment inspected annually. This includes the alarm panel, smoke detectors, pull stations and the kitchen Annsul System. There is also a requirement to have a sensitivity test on the smoke detectors every two years. The last sensitivity test was beyond the required two years. The administrator has contacted our fire alarm contractor and scheduled a smoke detector sensitivity test for 10/19/16. The documentation of date and results of the test will be filed with our alarm system reports in our Life Safety Code Binder. Person Responsible for compliance: The administrator will be responsible for monitoring on-going compliance with this code. Date of Correction: 10/25/16	10/25/16

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 _____	**09/15/2016**

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
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly maintain the automatic sprinkler system in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.3.5.1, and "The Standard for the Installation of Sprinkler Systems" 1999 edition section 3-2.7.2, 3-2.6.3, 5-5.6, and 6-1.1.5. This deficient practice does not ensure that the fire sprinkler system will function properly and is fully operational in the event of a fire and could negatively affect 14 of 57 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, observation and staff interviews revealed that the fire sprinkler system riser covering the 2005 addition had gauges that have not been replaced or re-calibrated every five years. This deficient condition was verified by the Administrator.	K 062	K062 St. Clare Living Community of Mora maintains the automatic sprinkler system in a reliable operating condition. Our systems are inspected annually by an outside vendor. The gauges in question were due to be change on July 2016. These gauges had not been replaced by the time of this inspection on 9/15/16. The administrator has contacted our contractor for our sprinkler system who will replace the gauges by 10/31/16. The administrator will monitor for on-going compliance with this code. Date of Correction: 10/25/16	10/25/16
K 070 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212	K 070		9/15/16

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K 070	Continued From page 6 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of NFPA 101 Life Safety Code (00), Section 18.7.8. This deficient practice could affect 40 of 57 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, it was observed that there were an unapproved portable space heaters found at the receptionist desk at the main entry of the facility. The portable heater was located in a resident non-sleeping areas and the facility could not provide any documentation or policy regulating the use of portable space heating devices within the facility. This deficient condition was verified by the Administrator.	K 070	K070 The facility does not allow use of the portable space heating devices in the building. The portable space heating device tag in the citation was not in use at the time of this inspection and it was not the equipment of the facility. It was immediately removed from the building. The facility has not changed its policy; portable space heating devices are not to be used in the building. The administrator will monitor for on-going compliance with this code. Date of Correction: 9/15/16	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the	K 144	K144 St. Clare is has a natural gas operated	10/25/16

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K 144	Continued From page 7 requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4, 6-4.1, and 6-4.2.2. The deficient practice could affect 57 of 57 residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 09/15/2016, during the review of all available emergency generator maintenance documentation and an interview with the Administrator it was revealed that the facility did not have a letter of reliable service for their natural gas fuel supply from the fuel company. This deficient condition was verified by the Administrator.	K 144	emergency generator. It was noted during the Life Safety inspection that the facility does not have a Letter of Reliable Service to ensure a fuel source for the generator. The administrator has contacted Minnesota Energy who supplies natural gas to the facility and has requested a Letter of Reliable Service from them. The administrator will monitor for on-going compliance with this code. Date of Correction: 10/25/16	