EPARTMENT OF	ARTMENT OF HEALTH AND HUMAN SERVICES MEDICARE/MEDICAID CERTIFICATION				'ATION AN	CENTERS FOR MEDICARE & MEDICAID SERVICES AND TRANSMITTAL ID: NVD0				RVICES	
			I - TO BE COM						acility ID: 008	314	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245291 STATE VENDOR OR MEDICAID NO. (L2) 064628000			(L3) ST CLARE L	3. NAME AND ADDRESS OF FACILITY (L3) ST CLARE LIVING COMMUNITY OF M (L4) 110 NORTH 7TH STREET (L5) MORA, MN			6) 55051	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	4. CHOW	2. Recertification	
EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 02/01/2011		7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (1	L7) 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint				
DATE OF SURVEY ACCREDITATION ST. 0 Unaccredited 2 AOA	11/01/2017 ATUS: 1 TJC 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE:	(L35)	
LTC PERIOD OF CER From (a): To (b):	TIFICATION		10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On:			And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director					
.Total Facility Beds .Total Certified Beds		5 (L18) 5 (L17)	B. Not in Comp	cceptable POC liance with Program and/or Applied Waiv		_	-Day RN (Rural SNF) ife Safety Code A*	8. Patient Room 8 9. Beds/Room (L12)	Size		
. LTC CERTIFIED BED 18 SNF (L37)	D BREAKDOWN 18/19 SNF 65 (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILIT	Y MEETS or 1861 (j) (1):	(L15)			
STATE SURVEY AGI	ENCY REMARKS (IF A	PPLICABLE S	SHOW LTC CANCELL Date :	ATION DATE):		18 STATE SI	JRVEY AGENCY API	PROVAL.	Date:		

Jen Bahr, HFE NE II

	PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY									
 19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Participate 		20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 							
2. Facility is not Eligible	(L21)		_							
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)						
OF PARTICIPATION 09/01/1985	BEGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety						
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement						
25. LTC EXTENSION DATE: (L27)	ALTERNATIVE SANCTION A. Suspension of Admissions B. Rescind Suspension Date:	: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active						
		(L45)								
28. TERMINATION DATE:	29. INTERMEI	DIARY/CARRIER NO.	30. REMARKS							
	0300	1								
	(L28)	(L31								
31. RO RECEIPT OF CMS-1539		IATION OF APPROVAL DATE	Posted 12/07/2017 Co.							
	(L32)	7 (L33	DETERMINATION APPROVAL							

Kate JohnsTon, Program Specialist 11/30/2017

11/01/2017

(L20)



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245291

November 30, 2017

Mr. Jack L'Heureux, Administrator St Clare Living Community Of Mora 110 North 7th Street Mora, MN 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 30, 2017, the above facility is certified for or recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 30, 2017

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

RE: Project Number S5291026

Dear Mr. L'Heureux:

On September 20, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 25, 2017. (42 CFR 488.422)

Additionally, on September 20, 2017 this Department recommended to the Centers for Medicare and Medicaid Services (CMS), and CMS concurred, that the following enforcement remedies be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective December 1, 2017. (42 CFR 488.417 (b))

Furthermore, on September 20, 2017, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil Money Penalty for deficiency cited at F155. (42 CFR 488.430 through 488.444)
- Civil Money Penalty for deficiency cited at F309. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on August 31, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 3, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 31, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 30, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 31, 2017, as of October 30, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 30, 2017.

St Clare Living Community Of Mora November 30, 2017 Page 2

In addition, as a result of the PCR findings, thyis Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 20, 2017. 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 1, 2017 be rescinded as of October 30, 2017. (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 1, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 1, 2017 is to be rescinded.

This Department recommended to the CMS Region V Office the following actions related to the recommended remedies in our letter of September 20, 2017:

- Civil Money Penalty for deficiency cited at F155 be imposed. (42 CFR 488.430 through 488.444)
- Civil Money Penalty for deficiency cited at F309 be imposed. (42 CFR 488.430 through 488.444)

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

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 30, 2017

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

Re: Reinspection Results - Project Number S5291026

Dear Mr. L'Heureux:

On November 1, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 31, 2017, with orders received by you on September 20, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: NVD0

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PARI	1 - 10 BE COM	ILTETED BA 1	HE STATE	E SURVEY AGENCY	Fac	eility ID: 00814	
MEDICARE/MEDICAID PROVIDER N (L1) 245291	O.	3. NAME AND AD (L3) ST CLARE I			MORA	4. TYPE OF ACTION:	2 (L8) 2. Recertification	
2.STATE VENDOR OR MEDICAID NO.		(L4) 110 NORTH	7TH STREET			3. Termination	4. CHOW	
(L2) 064628000		(L5) MORA, MN			(L6) 55051	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN	NERSHIP	7. PROVIDER/SU	PPLIER CATEGOR	Y	<u>02</u> (L7)			
(L9) 02/01/2011		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Com	plaint	
6. DATE OF SURVEY 08/31	/ 2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING D	ATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	e Following Requirements:	_	
To (b):		Program Re	equirements		2. Technical Personnel	6. Scope of Service	es Limit	
		Compliance	Based On:		3. 24 Hour RN	7. Medical Director	r	
		1. A	Acceptable POC		4. 7-Day RN (Rural SNF) 8. Patient Room Siz	ze	
12.Total Facility Beds	65 (L18)				5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	65 (L17)		npliance with Program and/or Applied Waiv		* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		ı			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
65					(4) (1) 11 1011 (1) (1)			
	(7.20)	(7.42)	a. 12)					
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AI	PPROVAL	Date:	
Austin Fry, HF	E NE II		10/12/2017	(L19)	Kate JohnsTon, Pr	rogram Specialist	10/13/2017 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE OR SINGLE STAT	ΓE AGENCY		
19. DETERMINATION OF ELIGIBILITY	•	20. COM	MPLIANCE WITH O	CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
1. Facility is Eligible to Part	ticinate	RIGHTS ACT:			 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	i.e.pute				5. Both of the Above .	· 		
2. Tacinty is not Engine	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT	24. LTC AGREEMI	ENT	26. TERMINATION ACTION:	(L3	30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY0	0 INVOLUNTA	RY	
09/01/1985					01-Merger, Closure	05-Fail to Mee		
					02-Dissatisfaction W/ Reimburseme		•	
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination	oo ran to wee	rigicoment	
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			04-Other Reason for Withdrawal	<u>OTHER</u>		
	A. Suspension	of Admissions:			04-Other Reason for withdrawar	07-Provider St	atus Change	
(L27)			(L44)			00-Active		
(=)	B. Rescind Sus	pension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL DA	TE	Posted 10/16/2017 Co.			
	(L32)			(L33)	DETERMINIATION APPRO	N74 I		
	(1114)			(123)	DETERMINATION APPRO	IVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 20, 2017

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

RE: Project Number S5291026

Dear Mr. L'Heureux:

On August 31, 2017, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fisher, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fisher@state.mn.us

Phone: (320) 223-7338 Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 25, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F155. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 1, 2017. (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 1, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 1, 2017. 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 1, 2017. 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, Acting Branch Manager by phone at (312)353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 1, 2017 (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 1, 2018 (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

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		245291	B. WING _		08/	/31/2017
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	0		
	was completed by some Department of Heal Community was for with the regulations B, requirements for The facility's plan of as your allegation of Department's acceptant of the bottom of the	/17, a recertification survey surveyors from the Minnesota Ith (MDH). St. Clare Living and to not be in compliance at 42 CFR Part 483, subpart Long Term Care Facilities. If correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will sign of compliance.				
F 155 SS=G	Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.10(c)(6)(8)(g)(7)	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with 12), 483.24(a)(3) RIGHT TO LATE ADVANCE DIRECTIVES	F 15	5		10/30/17
	discontinue treatme	equest, refuse, and/or ent, to participate in or refuse perimental research, and to ce directive.				
	construed as the rig the provision of me	s paragraph should be ght of the resident to receive dical treatment or medical nedically unnecessary or				
	requirements speci	must comply with the fied in 42 CFR part 489, DER/SUPPLIER REPRESENTATIVE'S SIGI		TITLE		(X6) DATE

Electronically Signed 10/02/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	245291	B. WING		08/	31/2017	
PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051			
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE	
subpart I (Advance (i) These requirement inform and provide residents concerning medical or surgical resident's option, for a facility's policies to and applicable State (iii) This includes a facility's policies to and applicable State (iii) Facilities are perentities to furnish the legally responsible requirements of this information or articular has executed an act may give advance of individual's resident with State law. (v) The facility is not provide this information to the information or she is able to recomplete time.	Directives). ents include provisions to written information to all adult ag the right to accept or refuse treatment and, at the armulate an advance directive. written description of the implement advance directives e law. ermitted to contract with other his information but are still for ensuring that the espection are met. Idual is incapacitated at the end is unable to receive allate whether or not he or she divance directive, the facility directive information to the expresentative in accordance at relieved of its obligation to action to the individual once he exive such information. The resident requiring such arrival of emergency in the resident requiring such arrival of emergency.	F 1:	55			
physician orders an	nd the resident's advance					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa subpart I (Advance (i) These requireme inform and provide residents concernir medical or surgical resident's option, fo (ii) This includes a facility's policies to and applicable Stat (iii) Facilities are pe entities to furnish th legally responsible requirements of this (iv) If an adult indivi time of admission a information or artice has executed an ac may give advance of individual's resident with State law. (v) The facility is no provide this informa or she is able to rec Follow-up procedur the information to th appropriate time. 483.24 (a) (3) Personnel pro including CPR, to a emergency care pri medical personnel pro including legant	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	PROVIDER OR SUPPLIER IE LIVING COMMUNITY OF MORA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION? OR LSC IDENTIFYING INFORMATION) Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information to the individual's resident representative in accordance with State law. 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Follow-up procedures must be in place to provide this information to the individual officety at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED			
		245291	B. WING		08/3	31/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	1 00/1	71,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROFICE OF THE APPROPROPROPROFICE OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO) BE	(X5) COMPLETION DATE
F 155	directives. This REQUIREME by: Based on observa review, the facility services according life sustaining trea who showed stoke immediately sent t (ED) as directed b actual harm for R7 condition, as a res her POLST. Findings include: R73's quarterly Mi 6/1/17, indicated s impaired, needed assistance of one (ADLs), she neede and physical assis were no other limit this assessment p R73's significant c identified the follow daily living (ADL) s assistance of one dressing and toilet indicated she was toileting, ambulate needed staff super with eating. R73 re impaired which wa R73's most recent identified R73 had	ENT is not met as evidenced ation, interview and document failed to provide emergency to POLST (provider orders for tment) for 1 of 1 resident (R73) symptoms, and was not to the emergency department by her POLST. This resulted in 73 who had a decline in her activities of daily living staff supervision with for activities of daily living ted set up assistance with eating teations of R73's ADL's during	F 155	F155 Right to Refuse; Formulat Advance Directives St. Clare Living Community of Morvery strong program and history of honoring our resident care wishes including any Advance Directives to may wish to develop. Our facility recognizes and encourages reside families to let their wishes be known care providers using the POLST protocols. During the survey the surveyors refunded to an incident pertaining to hospitalization on 6/10/17. Review R73 s POLST date and sign by the surveyors refunded to an incident pertaining to hospitalization on 6/10/17. Review R73 s POLST date and sign by the non 10/14/15, identified R73 was Defined Resuscitate or Intubate (DNR/DNI Section labeled Goal of Treatment included directions to be implement R73 has pule and/or is breathing, indicated R73 being on Comfort C several options that could be select accordance with R73 s wishes. It also box to check or not check next the area to clarify resident is wishes. It also box to check or not check or exist areas that can be checked are: Avoid call 911, call	hat they ents and yn to eviewed lan as it a y of ne CNP o Not). The nted if which are with eted in There is o each The oe filled epital ecked	

PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	13 FUR WEDICARE	& MEDICAID SERVICES			<u>UN</u>	<u>VIB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245291	B. WING			08/3	31/2017
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ST CLAH	E LIVING COMMUNIT	IY OF MORA		M	IORA, MN 55051		
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F 155	R73 required, "incre hospital with [stroke areas triggered on the assessment, which 9/22/16 CAA. R73 Mod 6/26/17, indicated Function and now has to recent CVA (cere (stroke) and used a she got caught on owhen in congested triggered due to receptive apharesident in finding the communication. The indicated R73 gets the correct words, identified now R73 of urine and needed was on a toileting peneded. The urinal indicated due to alt at greater risk for in indicated pressure CVA and was now of schedule every two was currently received and Occupation The and endurance relations and the shoulder against her shoulder against the strong process of the strong pr	initive CAA. However, now eased help since return from ease the 6/21/17 MDS for a CAA was not completed on the Visual Function CAA dated a73 had a change in vision related abral vascular accident) or wheelchair for mobility and other's wheelchair wheels areas. Communication CAA eatent CVA with a language sived speech for expressive sia and staff need to assist the ne correct words for the communication CAA further frustrated when unable to find The urinary incontinence CAA was occasionally incontinent dassistance with toileting and lan every two hours and as ry incontinence CAA further tered communication R73 was continence. The CAA also continence. The CAA also continence continence continence continence continence continence continence continence. The CAA also continence continence continence continence continence continence continence continence continence. The CAA also continence continence continence continence continence continence continence continence continence. The CAA also continence	F 1	55	Director of Nursing on 9/27/17 and resident chart. The facility has reviewed its Advance Directive policies and updated the Form to be more comprehensive an identify resident wishes clearly directore providers regarding resident with Education of the licensed staff on the revised Advance Directive policies a procedure will be conducted on Tue 10/3/17. General education on Advance Directive policies for all staff will be conducted at an all staff meeting on Thursday 10/12/17. An audit of all current residents POL was completed on 9/29/17 and updas appropriate. Then an audit of 25 current residents POLST will be completed weekly for four weeks; the 25% will be completed monthly for the next four months, then quarterly thereafter. Ongoing review of resid Advance Directives will also be consupon admission; upon hospital return at the resident Quarterly Care Conferences and any updates will be communicated according to our established policies. The Director of Nursing will be responsible for on-going monitoring compliance. The results of the audicurrent residents POLST will be repto the QA committee as will the reviational policies at their October meeting. Ongoing review of audits will become part of their regulations.	ce POLST d cting ishes. ne and esday, ance l LST ated % of the ent ducted rn; and be for it of ported sed of the ilar	
	and was propelling	st the rear frame of the chair, the wheelchair using both abling non nonsensical words,			audits will become part of their regu agenda for future QA Meetings. Fur system revisions and staff education	ther	

and had a furrowed brow facial expression.

be provided if indicated by audits and/or

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245291	B. WING		08/31	1/2017
	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PERCEGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 155	9:22 a.m. R73 was Nursing assistant R73 with morning on, and proceeded NA-J assisted and mechanical standing position f R73 in the mechar removed her visible and seated her on when seated on the washcloth to wash perineal area. R73 bathing. NA-J state and transferred on sustained a stroke required a mechar wheelchair for molambulate.	It observation on 8/30/17, at a lying in bed in her room. (NA)-J entered the room to help cares. NA-J put R73's socks it to assist R73 to sit up in bed. It is strapped R73 into a lift, and assisted to a rom her bed. NA-J wheeled hical lift to the bathroom, by soiled incontinence product the toilet. R73 did not void lift to the bathroom, and it is strapped R73 in the toilet. R73 did not void lift to the bathroom, and it is strapped R73's face, back, arms and it is did not participate in the led R73 used to be ambulatory and her own, however, R73 and a few months ago and now hical lift for transfers, used a billity and was unable to	F 155	recommended by the QA Comm Date of Correction: 10/30/17	ittee.	
	family member (FM)-A was R73's emergency contact, responsible party and the person to call it a change in condition. Further, the sheet indicated FM-B was the secondary contact.					
	member FM-A star would be notified of accident, with R73 ago (R73) develop facility attempted t message on her p in condition and th and wanted me to wasn't sent to the	n 8/29/17, at 1:41 p.m. family ted she was the person who of a change in condition, or so factorized a few months and stroke symptoms and the o call her, however, just left a hone about her sudden change ey thought she had a stroke call back they didn't say she hospital. FM-A stated she did				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		08	/31/2017
-	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP C 110 NORTH 7TH STREET MORA, MN 55051		70172011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 155	When she called the sent (R73) to the from FM-A stated she to the emergency room for thought if someon have gone in right unaware why the fimmediately to the the facility waited the emergency room for the form to (R73) that was the hospitalized FM-A. During interview 8 director of nursing up on 6/10/17, and the should have the department right at that FM-A would we staff should not have the form the form the form of the fo	he facility back, they had not nospital for these symptoms. old staff to send R73 to the or treatment immediately and e had stroke symptoms should away. FM-A stated she was acility did not send her hospital, adding she was upset oo long to send (R73) to the	F1	55		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245291	B. WING _		กล	3/31/2017	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 110 NORTH 7TH STREET MORA, MN 55051		,,01/2011	
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F 155	hospital discharge did not return the puring interview 8 stated LPN-C was and was R73's nu spoke to LPN-C a waited for the fam sending her in was (CNP)-A told him twanted to do first. remember is he contact. During interview 8 stated on 6/10/17, the symptoms R73 based on past coronly wanted things and wanted (R73) infection and if it will didn't want her ser (R73) had a brain pain. FM-A wasn'they would not wa having stroke symptomes and wanted (R73) in fection and if it will want her ser (R73) had a brain pain. FM-A wasn'they would not was having stroke symptomes and stated day it happened, I buring interview 8 facility medical director stated if a hers and was having should have been right away and not stated in the same way and not should have been right away and not stated in the same way and stated in the s	summary on 6/12/17. MD-A	F 15	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		30	3/31/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 110 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 155	they could have w reviewed the eme stated MD-B was "Reading MD-B no you have to assum had no CVA symp they decided not t time had passed. stroke could be a would make sense away". During interview 8 stated during an expect the facility practitioner, and for contact the primar the secondary corresident in. The D waited for the familiates sent her in. The a specific policy stated he was R73 she woke up her in paralysis so he cashe didn't think the ED because of LPN-C stated her in right a unable to recall the had not received a unsure if he attern contact FM-B. LP much time had paralysis had paralysis had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had not received a unsure if he attern contact FM-B. LP much time had paralysis had not received a unsure if he attern contact FM-B.	age 7 nething that was not so urgent aited. The medical director regency department note and the emergency room physician. The and was sleeping at 1430 me this was the last time (R73) toms. When she got to the ED reat with tPA because too much The medical director stated a reversible condition and it to send her to the ED right //31/17, at 11:19 a.m. the DON mergency situation she would to call the physician or nurse amily. If they were unable to y contact, then they should call stact and then just send the ON stated they should not have interested to a facial droop and that but it is their protocol. //31/17, at 12:57 p.m. LPN-C are noted a facial droop and led the CNP-A, who told him to the family would want her to go to find the family would want her to go to find the called back she told me to way. LPN-C stated he was the events after calling FM-A, but a call back right away and was pted to call the secondary N-C stated even though so seed, he had not heard from ecall calling CNP-A again about	F 1	55		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245291	B. WING			08/;	31/2017	
	PROVIDER OR SUPPLIER	TY OF MORA		11	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 7TH STREET ORA, MN 55051			
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F 155	did not seem too come of the seem to come	each FM-A, because CNP-A oncerned. 2 p.m. a call was placed to the was left for MD-B. MD-B did 31/17 at 1:33 p.m. CNP-A recall if LPN-C called her on being able to reach (R73's) to away. CNP-A stated even if again, she would not have not ion because she was under the lid not want to treat (R73). 31/17, at 3:16 p.m. FM-A alled her on 6/10/17 and left are facility did not call FM-B who dary emergency contact. Trovider Order for Life ent (POLST) dated and signed aurse practitioner (CNP)-A on a R73 was do not resuscitated (DNI). A section labeled, ant," included directions to be 3, "has pulse and/or is indicated R73 being on, th several options that could be ance with R73's wishes. There is or not check next to each of a call [blank line to fill in] of transport to ER [emergency]	F 1	55				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		245291	B. WING			08/31/2017	
	PROVIDER OR SUPPLIER	TY OF MORA		110	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 7TH STREET ORA, MN 55051	,	
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F 155	However, all of thes unchecked, identify completed. Furthe checked option for, Reversible Condition interventions aimed reversible illness / i chronic conditions, ER presumed." The	se options were left ving R73 wanted these actions r, R73's POLST identified a "Limit Interventions and Treat ons," which described, "Provide d at treatment of new or njury or non-life threatening "further listing, "Transport to be POLST was signed by R73, ted.	F1	55			
	indicated, "Noted [F before dinner at 16 unsteady gait, RT [non-reactive, slurre hand/foot strength BP [blood pressure [respiration rate] 18 blood] 97% on RA 96.7. Family notifie	e dated 6/10/17, at 18:23 R73] was difficult to rouse 15. Noted resident with right] facial droop, RT pupil ed/slow speech, and bilateral WNL [with in normal limits]. el 149/52, P [pulse] 73, RR el, Sp02 [oxygen saturation in [room air] and T [temperature] ed writer at 1815 that they want he hospital to get checked out."					
	dated 6/10/17, indic 18:21 and the prim neuro-stroke/cva. F 6/10/17, at 18:50 vi minutes after R73's	System Ambulance Report cated dispatch was called at ary impression was R73 arrived at the hospital on a ambulance, 2 hours and 35 is significant change in cified at the nursing home.					
	identified R73 had (stroke). The report old female with a himeningioma (non-cfrom the membrane)	oort dated 6/10/17, at 6:49 p.m. a primary diagnosis of CVA rt indicated she was a 75 year					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245291	B. WING		80	/31/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051			
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F 155	admitted with probher primary deficit difficulty and will confor secondary preventerapy were order the report indicated was done and completed on 10/0 CSF (cerebral spir hydrocephalus (fluaway). The CT sacute intracranial activation conformation and because intracranial activation and because in the coordination and because the coord	HTN (hypertension) and was able CVA. The report indicated was confusion with speech ontinue Plavix (blood thinner) rention. PT/OT and speech red at the hospital. In addition d a CT (cat scan) of the head apared to a previous CT 9/15, the findings indicated real fluid) spaces with no id in the brain), atrophy (waste can impression indicated no abnormality, stable atrophy and el ischemic (restriction of ble anterior lateral left the brain that controls alance) meningioma and all lobe infarct (stroke). A the ED to Hosp-Admission 6/11/17, that R73 was	F 1	55			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED			
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	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		1 00/01/2011		
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F 155	that time, too much known normal time activator that is iso dissolves the clot a part of the brain de an option. Pt has shistory and exam of (fevers/chills), chest breath), cough or t (unclear how reliable A First Light Health Physician Criteria flast revised 2/11/10 Inclusion Criteria: -Clearly defined tin-tPA can be given to onset -Patients over 18 -The patient's sym	age 11 Initially reversible condition). By a time had passed from the last a so tPA (tissue plasminogen hemic stroke treatment that and improves blood flow to the eprived of blood flow) was not significant dementia making difficult. Denies any f/c at pain, sob (shortness of rouble going to the bathroom ole pt is.) no other concerns." In System Mora, Minnesota for tPA Use In Stroke guidelines D, indicated the following the of onset of symptoms within 3 hours of symptoms are clearly consistent to stroke with measurable		55				
	dated 6/15/17, com was seen for a long primary diagnosis of the control of the co	nsitions Long Term Care Visit appleted by CNP-A indicated she geterm care visit and her was acute CVA. The HPI illness) on the report indicated or old female with past medical or dementia, old CVA with right abetes mellitus, meningioma. She felt ill on 6/10/17 and laid en she awoke, she had on, unstable gait, and difficulty is brought to ED for evaluation d an acute CVA. She med to St. Clare on 6/12/17. ave deficits in speech, difficulty						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245291	B. WING			08/3	31/2017
	PROVIDER OR SUPPLIER RE LIVING COMMUNI	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CO 110 NORTH 7TH STREET MORA, MN 55051	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD I	BE	(X5) COMPLETION DATE
F 155	mechanical soft die She is wheelchair bunstable." The rep the nursing home for primary deficits in cand referrals were her diet changed to mechanical soft. Although R73 had a 6/10/17, with stroke to provide prompt esending R73 immer R73's POLST, which treatment for revers failure to respond in R73 from receiving sensitive and must hours to reverse stinot receiving this misgnificant change is dependent upon start R73 by not following the medical record. The based on wishes of representative ager regularly and kept of the nursing staff, phinvolved with the caplan that states the they want to manage This form will addressed to the end of the e	reased confusion. She is on at with honey thickened liquids. Sound, gait and balance ort indicated R73 returned to collowing an acute CVA, sognition, speech and swallow made to PT/OT/SLP. R73 had a honey-thick liquids, a change in condition on a symptoms. The facility failed emergency treatment by not diately to the ED following the outlined R73 wanted sible conditions. The facility's in a timely manner, prevented tPA medication, which is time be administered within 3 roke symptoms. As a result of redication, R73 had a n her ADL's and was aff, resulting in actual harm to	F 1	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION IG	` '	E SURVEY IPLETED
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F 166 SS=C	(j) (2) The resident is must make prompt grievances the resident with this paragraph (j) (3) The facility must of file a grievance or resident. (j) (4) The facility must of ensure the promover regarding the resident paragraph. Upon real copy of the grievance policy must of the grievance policy must of the grievance policy must of the grievance anonymous facility of the right to (meaning spoken) of grievances anonymous facility of the right to (meaning spoken) of the grievance off can be filed, that is, address (mailing arnumber; a reasonal completing the reviet of obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State Laprogram or protectic (ii) Identifying a Grieresponsible for over	nas the right to and the facility efforts by the facility to resolve dent may have, in accordance dent may have, in accordance destinated in the facility to resolve dent may have, in accordance destinated in the facility of the facility accordance dents and the facility of the facility	F 16			10/30/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 166	by the facility; mair information associal example, the ident grievances submitty written grievance of coordinating with some necessary in light of the coordinating with some necessary in light of the coordinating with some necessary in light of the coordinating with some necessary, prevent further pot right while the allegation in the coordination of the portion of the portion of the peregarding the residuant to summary of the peregarding the residuant the date the work of the residents' rigor if an outside entire the steps taken to summary of the peregarding the residuant the date the work of the residents' rigor if an outside entire the steps taken to summary of the peregarding the residuant the date the work of the residents' rigor if an outside entire the steps taken to summary of the peregarding the residents of the residents' rigor if an outside entire the steps taken to summary of the peregarding the residents' rigor if an outside entire the steps taken to summary of the peregarding the residents' rigor if an outside entire the steps taken to summary of the peregarding the residents' rigor if an outside entire the steps taken to summary of the peregarding the residents' rigor if an outside entire the steps taken to summary of the peregarding the residents.	ing any necessary investigations intaining the confidentiality of all atted with grievances, for ity of the resident for those and anonymously, issuing lecisions to the resident; and tate and federal agencies as of specific allegations; taking immediate action to ential violations of any resident ged violation is being a §483.12(c)(1), immediately diviolations involving neglect, juries of unknown source, fation of resident property, by services on behalf of the ministrator of the provider; and	F 16				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 166	confirms a violation rights within its area (vii) Maintaining evi result of all grievan 3 years from the iss decision. This REQUIREMED by: Based on observareview, the facility fresidents and familifacility. This practic 56 residents in the Findings include: Resident council mindicated residents in the facility. An at the concern; howevindicated. Resident dated 8/14/17, did addressed with the During observation room on 8/28/17, aflying around the dilanded on R3's left fruit crisp. R3 swatt times, as it continues tated "They [flies] During interview on member (FM)-A sta of flies on their food	cal law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced tion, interview and document ailed to resolve concerns from ites regarding flies in the e had the potential to affect all facility. eeting minutes dated 7/25/17, had a concern related to flies tached grievance form noted ver, no response was council meeting minutes not indicate the flies had been resident council. of brunch in the main dining to 10:37 a.m. several flies were ning room. At 10:49 a.m. a fly hand as she was eating her ted the fly off her hand multiple busly landed on her hand. R3 sure like me." 8/28/17, at 10:52 a.m. family ated "Everyone is sick and tired dand their cups, they [the	F 10	F166 483.10 (j)(2)-(4) Right to Prefforts To Prompt Efforts To Resources St. Clare Living Community of Moan established grievance policy a procedure to ensure the prompt resolutions of all grievances. This procedure includes identifying the interviewing the person who filed complaint to ensure clarification of issue, and assigning it to a staff of the to resolve and/or follow up on the In the summer of 2016 the issue flies was address with the installated pest control light in the main dining and at the delivery entrance. This communicated to the residents, fastaff at that time. It appeared to rethe issue for the main dining room spring of 2017 we purchased two additional Pest Control lights for Statement of the main dining room.	ora has and se issue, the of the nember issue. of the tion of ag room is was amily and esolve in. In the south growing to that oors in		
	member (FM)-A sta of flies on their food facility] don't do any	ated "Everyone is sick and tired		courtyard is through the French d	oors in M)-A on		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RE LIVING COMMUNI	TY OF MORA	1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 7TH STREET MORA, MN 55051		
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F 166	although the facility decrease the flies thad not addressed. On 8/28/17, at 10:5 did not do anything stated "it [the flies]. When interviewed nursing assistant (I few complaints about NA-D further stated instruction on what handle the resident. During interview or stated there were mand noticed them in the dinit two ago and stated of the problem. The voiced complaints at the complaints a	ry day. FA-A further stated that a had completed steps to the previous year, the facility the concerns this year. 66 a.m. R6 stated the facility about the flies. R6 further bothers me when I'm eating," on 8/28/17, at 10:58 a.m. NA)-D stated there had been a but the flies in the dining room. It is complaints about the flies. a 8/29/17, at 12:28 p.m. R82 numerous flies hanging around nainly in the dining room. p.m. the certified dietary ated the flies had become a ng room again about a week or I the administrator was aware a CDM further stated FM-A had about the flies.	F 166	He will be meet again with (FM)-A of 9/29/17 to follow up with him and to discuss the additional steps that we taking to address the fly issue. The Grievance Policy and Procedur have been reviewed and revised. Education on the revised policy will conducted at the All Staff Meeting of October 5, 2017. The updated policy be reviewed with the Resident Cour October 9, 2017. Communication of revised policy and procedure and the revised Customer Concern form with sent to all current resident families later than October 20, 2017. Also the policy and Customer Concern form included in the admission packet for new admissions. Customer Concerns will be reviewed the facility 's daily management meincluding items identified at the more resident council meeting. All open concerns and closed concerns will reviewed at the monthly management meeting to determine additional interventions and/or compliance. A summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report of the concerns will presented at the Quarterly QA for full summary report o	be b	
	wellness director (\text{V} mentioned flies at t July. WD stated fol meeting, WD broughthe administrator. Versident council mecomplaints regardinot ask the resident concerns and the resident concerns	WD) stated the residents the resident council meeting in lowing the resident council ght the resident concern to the WD stated at the August eeting residents had no ng the flies. However, WD did ats specifically about fly esidents were not given a evious months concern about		review and input on trends. The Director of Social Service will be responsible for monitoring for on-go compliance. Date Corrected: 10/30/17	oe e	

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		245291	B. WING			08/	31/2017
	PROVIDER OR SUPPLIER	TY OF MORA		110	REET ADDRESS, CITY, STATE, ZIP CODE NORTH 7TH STREET DRA, MN 55051		
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F 166	administrator stated through the french the doors were operactivities in the courstated he was award members complaints. FM-A's complaints. facility placed fly lig moved the facility of to reduce the flies. had not addressed about the flies this correct the issue. The had not contacted contractor this year. On 8/31/17, at 3:48 administrator had raddressed his fly of further stated it was	a 8/31/17, at 1:22 p.m. the dight the flies were coming in doors in the dining room, as en, to allow residents to attend rtyard. The administrator re of the resident council at about the flies, as well as The administrator stated the hts through out the facility and lumpster last year in an effort The administrator stated he resident and family concerns year as he wasn't sure how to the administrator further stated ed the facility's pest control regarding the flies. It p.m. FM-A stated the rever verbally or in writing oncern in the facility. FM-A is pointless to complain giver gets done about the	F1	66			
F 226 SS=C	Grievances indicate not limited to a form but may include a r to staff. The staff presolves the issue, customer within five 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES	•	F 2	26			10/15/17

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F 226	written policies and (1) Prohibit and pre exploitation of resident property, (2) Establish policies investigate any successive any successive any successive any successive any successive and successive any successive and successive any successive and successi	procedures that: vent abuse, neglect, and lents and misappropriation of es and procedures to h allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum constitute abuse, neglect, isappropriation of resident	F 2	F226 Development/Implement Abuse/Neglect Policy It is the policy of St. Clare Live Community to prevent and pure sidents from abuse, neglect exploitation, and misappropring property. It is also the policy Living Community to not emptode the state of the policy of	ring rotect all ct, financial iation of of St. Clare	

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F 226	Nursing, dated as rescreening of All Por "Criminal backgrou" Review of nursing a resource file, it was hired on 9/30/15, w 10/5/15 received, in provide direct care. In further review of was noted that on 4 termination her emplowever, NA-A was later), with no evide background study is state agency for revulate agency for revulate they thought grace period after a screen and the state of the s	buse Prevention Plan for evised 11/16, identified in tential Employees that and checks will be conducted." assistant (NA)-A's human noted NA-A was originally ith a background study dated adicating NA-A was able to NA-A's human resource file, it by 12/17, NA-A voluntary bloyment from the facility. It is rehired on 5/6/17, (35 days ince that an updated and been submitted to the	F 2	226	individuals who have been found guabuse, neglect, mistreatment, finan exploitation, or misappropriation of property. Employee NA-A has been off the schedule. Employee will have criminal background study complete prior to her return to St. Clare Living Community. All potential employee be screened and/or re-screened if employee is a re-hire, for a history of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law of a vulnerable adult. As part of the screening process: a.) Inquiries will be made into the slicensing authorities or Nursing Ass Registry. b.) The facility will prohibit employmindividuals with disciplinary action in against their professional license by state licensure body as a result of find fabuse, neglect, exploitation, mistreatment of residents, or misappropriation of property. c.) Criminal background checks will conducted. All new employee files will be audited to the first day of General Orientation current criminal background study, addition, all current employee files was a udited to ensure compliance with background studies by October 15, The issues identified in this FTag we discussed with all staff at their all staff at their all staff at their all staff and their all staff at their all staff at their all staff and responsible for compliance will be responsible for compliance. The results will be reported to the QA/Q	state state state in the ed prior on for line will be ed prior on for line	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 226	Continued From pa	ge 20	F 2	26	Committee at their October 2017 M for further review and recommenda Upon this review, system revisions implemented if indicated via a pres corrective action plan. Date of Correction: 10/15/17	ation. will be	
F 279 SS=D	assessments comp months in the residence results of the assess and revise the residence		F 2	79	Date of Composion. To/To/Ti		10/30/17
	comprehensive pereach resident, consist forth at §483.10 includes measurable to meet a resident's and psychosocial necomprehensive assignated care plan must describe that or maintain the resign physical, mental, ar required under §483.	t develop and implement a son-centered care plan for istent with the resident rights (c)(2) and §483.10(c)(3), that e objectives and timeframes medical, nursing, and mental eeds that are identified in the essment. The comprehensive					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED 08/31/2017	
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NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		
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F 279	under §483.10, incomprehensive can limit lymphedema, several several limit lymphedema, several limit lymphedema, several lize and treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations findings of the PAS rationale in the result recommendations findings of the PAS rationale in the result recommendation resident's representation of the passion of the	e resident's exercise of rights shuding the right to refuse 483.10(c)(6). It services or specialized ces the nursing facility will of PASARR If a facility disagrees with the SARR, it must indicate its ident's medical record. with the resident and the ntative (s)- goals for admission and preference and potential for facilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate rpose. It is in the comprehensive care te, in accordance with the orth in paragraph (c) of this NT is not met as evidenced attion, interview and document	F 279	F279 Develop Comprehensive Ca Plans It is the policy of St. Clare Living Community of Mora to use the result assessment to develop, review, and revise the resident comprehensive p care. Resident R53 does have a comprehensive care plan which was reviewed and revised on 8/2/17 at he	s of lan of	

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F 279	quarterly Minimum 7/20/2017, indicate was independent with staff to complete as behavior issues. R53's current Phys 8/31/17), identified (consistent carbohy restriction 1800 ML NO sweeten bever at bedside at one to the same staff personal medications and water for her to tak stated the nurse wate	Data Set (MDS), dated and R53 was cognitively intact, with minimal supervision of 1 ctivities of daily living, with no scician Order Report (print date the following diet: "CSC ydrate) 2 gram sodium (milliliter) FR (fluid restriction) ages in room *MAX of 500 ML ime" diet. We have a lady on nights and asked for ice one night and she have any and that I have the night." R53 further stated son came in to give her 4:30 and was mad. She did not have the with the medication. R53 as "very rude to me" and "we times." R53 stated that she urse to the director or nursing has changed. I on 8/29/17 at 6:20 p.m., R53 lity hall on the facility's north machine is located) pedaling h her feet, holding a large rmal mugs full of ice chips,	F 279	quarterly care conference. During survey R53 displayed behavioral is pertaining to her fluid restrictions. included disruptive interaction with care giver in an attempt to get fluid side of her current restrictions. To comprehensive care plan did incluidentification of behavior issues wi interventions. However, it did not interventions pertaining to manipulate behaviors. R53 s comprehensive care plan or reviewed and revised by the IDT to include interventions for manipulate behaviors on 9/29/17. Education on updating and develocomprehensive care plans with intervention was conducted on 10/4 Audit of comprehensive care plans residents who have identified behaviors will be conducted by 9/29/1 ensure that the care plan is compliancluding effective interventions. identification of behaviors will be discussed with the IDT team on a basis (M-F) at their morning meetinecessary interventions will result updating of the care plan, and behavioring sheets. Results of the audits will be reported to the QA/C committee at their quarterly meeting the part of the committee at their quarterly meeting the committee at the comm	ssues This direct dout ne de th include ative vas eam to ive ping 3/17. s for aviors 7 to ete, Further daily ng; any in the avior se el		

-	ATEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 110 NORTH 7TH STREET MORA, MN 55051		
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F 279	was placing ice cull bottles and placing recliner chair, leaving recliner chairs and recommendation of fluid restrictions [cubic centimeters] [nursing assistant] [water] between 23 At 0430 resident reproperty property of the continuent of the continuen	them on the floor next to her ing her ice mug empty. edical record progress notes, documented by facility staff: t requesting more fluids at of the night. Resident currently and able to receive 360cc's during the night shift. NAR gave resident 360cc's of H2O 800-2400 per resident request. Equests that writer bring her or pain to her back area. Writer along with other early a.m. tions. When writer arrived with adiately stated in a snarky ave something to drink for me be your the [drinking] police and have anything." Writer and restrictions stating she was reders per MAR. Resident et raising her voice, yelling at [profanity used], and a not an attitude. NAR was standing tening to whole conversation uring resident yell at writer all room. Writer attempted to calm the did not work resident writer, put her down and be writer gave resident about ake medication with. Resident with med cup towards writer. BS	F 2	279		
	insulin administere	ucose prior to brunch: 392. d as ordered. to DR for both s activity. filled ice pitcher X 2				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245291	B. WING			08/	31/2017
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP 110 NORTH 7TH STREET MORA, MN 55051	CODE		
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F 279	to resident to inform (fluid restriction) mashe keeps tract of he resident to inform (fluid restriction) mashe keeps tract of he resident and consumes fluid approaches for the prescribed diet with (dated 7/10/17) "proordered - fluid restrictions with starelated issues. During an interview licensed practical nevening, stated that the evenings, but he (R53) is still mad the enforcement of R53 restriction, while shwater every evening. Review of R53's So (from original admission the section of BE Social Service update admission (on 2/8 within the narrative fluid restrictions."	per self. writer recommended in staff of this so accurate FR ay be followed. resident stated her fluids." Imprehensive care plan, last id not identify any behavioral priefly in the nutritional section insumes food and fluid outside and fluid restrictions. Obtains defood independently." The inutrition care plan, listed the in the handwritten addition by the handwritten addition by the handwritten addition by the handwritten addition as ordered. There was is behavior and verbal aff regarding these care on 8/30/17 at 7:29 a.m. urse (LPN)-B, who worked it "R53 use to ask for water in as not recently." LPN-B stated at LPN-B was encouraging 3's physician ordered fluid e would ask for both ice and	F 2	279			
	worker (SW) stated	I the interdisciplinary team vith R53 in regards her fluid					

			(X3) DATE SURVE COMPLETED	Y		
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	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE I10 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉ	TION
F 282 SS=D	believes is correct.' During an interview nurse practitioner (I multiple education a cardiology and facilifollow these restricts. On 08/31/2017 at 8 nursing (DON) state behaviors of refusirinterventions, and if facility and outside resident has the rig however, the facility educate staff on however, the services provide as outlined by the care. This REQUIREMED by: Based on observative review, the facility for directed by the care.	on 8/30/17 at 1:55 p.m., the NP)-A stated (R53) has had settings, with nephrology, ity staff, and continues to not ions. :36 a.m. the director of ed R53 has displayed ng physician ordered health had been education by both medical staff. DON stated that ht to refuse treatment, a needs to care plan and w to respond to R53's mpliance. RVICES BY QUALIFIED ARE PLAN ive Care Plans led or arranged by the facility, omprehensive care plan,	F 279		vices with	17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER. `		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING			08/	31/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	R73's significant ch (MDS) dated 6/21/1 limited assist with p further indicated sh limited assist of one R73's care plan darwas at risk for poor dementia. The carhad impaired activito diagnosis of demas evidence by (AE dressing, grooming During observation was observed to be day room with multichin down to the mapproximately 3/8 i During observation was sitting in her with doorway with viand chin. During interview 8/2 medical assistant (good with receiving toileting but she will subsequent interviel looking at R73's facts something that coushould have been sher bath day."	nange Minimum Data Set 17, identified R73 needed personal hygiene. The MDS ne was endtulous and needed re for personal hygiene. Ited 10/21/15, indicated she re roral hygiene related to re plan further indicated R73 ties of daily living (ADL) related mentia, and cerebral infarction, relations assist with relation and hygiene. on 8/28/17, at 1:20 p.m. R73 resitting in her wheelchair in the riple visible facial hair on her riddle of her neck reches in length. 8/29/17, at 12:26 p.m. R73 reside heelchair in the south hall by rible facial hair on her face 29/17, at 6:45 p.m. trained reches she might say no to reches allow us to do grooming. In rew at 7:06 p.m. TMA-A stated reches in length that she reches in length say no to reches she might	F 2	the ree are ide with ree are ide with the control of the control o	e resident R73 the care plan and esident assignment sheet were rend revised. The issues that were entified in the survey were addressith the direct care staff responsible 73 on 8/30/17. Education for direct aff pertaining to oral care and pergiene (including facial hair) was producted at the NA/R meeting held of 12/17. This topic was also discrete the licensed staff meeting held of 1/3/17. We residents who are dependent of the ersonal care will be monitored threat care and facial hair audits whice conducted three (3) time per well days; then weekly for 30 days; or three months; and then random ereafter. Results of these audits eported to the QA/QI at their quart eetings. Further system revision aff education will be provided if in a audits and/or recommended by A/QI committee. The director of nursing or designed esponsible for monitoring on-going ompliance. The resident R73 the care plan and responsible for monitoring on-going ompliance.	ssed e for ct care sonal d on ussed n upon ough ch will ek for nonthly ly will be erly and dicated the		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 282	from her chin to the assistant (NA)-J en R73's socks on proshe brought a standattached the straps proceeded to lift he the lift. NA-J then we bathroom removed lowered her onto the towash her face, by area and dressed hup with the standing wheelchair. NA-J towash on the standing wheelchair. NA-J towash on the composition of the provide oral director of nursing the removing facial and it could also be they notice it. The care should be don the pool of the pool of the have been shaved DON stated a. residents up for the have been shaved DON stated she will her and do oral care are cares when I got he completed these cay when I was informed.	in bed with visible facial hair middle of her neck. Nursing tered the room. NA-J put ceeded to sit R73 up in bed ding lift to her bed and under her arms and r up in a standing position with wheeled the lift to the her incontinent pad and e toilet. NA-J then proceeded ack arms and legs and periner. NA-J then lifted R73 back go lift and lowered into her hen stated all we have left to ur hair. NA-J combed R73's led her into the hallway. NA-J care or shave her facial hair. 30/17, at 11:39 a.m. the (DON) stated the staff should hair as they are doing cares adone during there bath or if DON further indicated oral e with a.m. and p.m. cares. m. cares is when they get the morning and that she should and received oral care. The let the staff know to shave es. 30/17, at 1:59 p.m. NA-J primed her that R73 did not and was not shaved with a.m. er dressed in the morning. I ares after her lunch today and by the DON. NA-J further	F 2	82		
F 309	•	es these cares after lunch.) PROVIDE CARE/SERVICES	F 3	09		10/30/17

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F 309 SS=G	FOR HIGHEST WE 483.24 Quality of life Quality of life is a frapplies to all care a residents. Each refacility must provide services to attain or practicable physical well-being, consisted comprehensive assembles to all treatments facility of care is a applies to all treatments facility residents. Be assessment of a residents receive accordance with propractice, the comprehensive and the resident with provided to resident consistent with profit the comprehensive and the residents' of the comprehensive and the residents who requiservices, consistent of practice, the comprehensive and the residents who requiservices, consistent of practice, the comprehensive and the residents who requiservices, consistent of practice, the comprehensive and the residents who requiservices. This REQUIREMED by:	fe undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest al, mental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure eve treatment and care in ofessional standards of rehensive person-centered residents' choices, including e following:	F 30	F309 Provide care/services for h	nighest	

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F 309	emergency medica (R73) who had strostroke which cause limited R73's ability living (ADL's), that Findings include: R73's quarterly Min 6/1/17, indicated simpaired, needed sassistance of one f (ADLs), she needed and physical assist were no other limitathis assessment per R73's significant chidentified the follow daily living (ADL) stassistance of one with dicated she was toileting, ambulated needed staff superwith eating. R73 reimpaired which was R73's most recent Assessment (CAA) had dementia with making, which was Cognitive CAA. How "increased help sin [stroke]." The followas a result of chang R73's Visual Functions."	ailed to provide timely I services for 1 of 1 residents ke symptoms and subsequent d physical impairment that to complete activities of daily resulted in actual harm. imum Data Set (MDS) dated he was severely cognitively taff supervision with or activities of daily living d set up assistance with eating ance of one for bathing. There ations of R73's ADL's during	F 30	well being It is the policy of St. Clare Livir Community of Mora to provide resident with the necessary caservices to attain or maintain the practicable physical, mental, as psychosocial well-being, in act with comprehensive assessment plan. The care plan and the Advance (POLST) was reviewed and resplan. The care plan and the Advance (POLST) was reviewed and resplan. The facility has reviewed and resident wishes directing care regarding resident wished. The Emergency Care was also revised by IDT 9/29/17. Education of the licensed staff revised Emergency Care and Advance for all staff was conducted on 10/03/17. General education Emergency Care and Advance will be conducted on 10/05/17. More specific education of the licensed staff on Emergency Care and Advance will be conducted on 10/12/17. Audits of staff on Emergency Care/Situational Events and Advance will be conducted at following rate: 4 staff audits provided the next three month; then 3 sequarterly thereafter. Emergency Care Events will be at the daily (M-F) IDT meeting current interventions and discurrent inter	e each are and he highest and cordance ent and care e Directive evised on wed its d updated entify providers he policy for iewed and fon the edures and ted on on e Directives Thursday ation on e Directives the er week for month for taff audits e reviewed to assess	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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ST CLAF	RE LIVING COMMUN	ITY OF MORA		110 NORTH 7TH STREET MORA, MN 55051			
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F 309	CVA (cerebral vas used a wheelchair on other's wheelch areas. R73's Conto recent CVA with received speech fraphasia and staff finding the correct communication Control of the urinary inconto was occasionally it assistance with to plan every two horincontinence CAA communication Rincontinence. The ulcers triggered did a turning and report of the cere incontinence of the cere incontinence. The ulcers triggered did a turning and report of the cere incontinence of the cere incontinence of the cere incontinence of the cere incontinence of the cere incontinent of urindiagnosis of demostroke) and needed.	I cut vision related to recent cular accident) or (stroke) and for mobility and she got caught hair wheels when in congested munication CAA triggered due a language deficit resident or expressive and receptive need to assist the resident in words for communication. The AA further indicated R73 gets hable to find the correct words. inence CAA identified now R73 incontinent of urine and needed illeting and was on a toileting aurs and as needed. The urinary further indicated due to altered a Was at greater risk for a CAA also indicated pressure are to post CVA and was now on esitioning schedule every two ded. She was currently Therapy (PT) and Occupation strengthening and endurance	F3	alternate possible interverecommendations for charmonic Emergency Care Plan. Freviewed by the QA/QI confurther recommendations revision and staff education provided if indicated by Care The Director of Nursing veresponsible for monitoring on-going compliance. Date: 10/30/17	anges to Results will be ommittee for s. Further system on will be QA/QI committee. vill be		

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F 309	care plan indicated mobility related to oright sided weakness extensive assist of independent with be assistance of one volume of the participate in her batto be ambulatory and however, R73 sustango and now require transfers, used a wundeled on member (FM)-A standing indicated on member (FM)-A standing indicated on member (FM)-A standing interview on m	R73 was at risk for impaired diagnosis of cerebral infarction, as (hemi paresis) and needed one with transfers, was eed mobility and needed with a rolling walker. 8/29/17, at 6:54 p.m. R73 was d wheelchair in the South wing eaning to the right side with at the rear frame of the chair, elchair using both feet. R73 sensical words, and had a all expression. observation on 8/30/17, at lying in bed in her room. NA)-J entered the room to help eares. NA-J put R73's socks to assist R73 to sit up in bed. strapped R73 into a glift, and assisted her to a om her bed. NA-J wheeled ical lift to the bathroom, a soiled incontinence product the toilet. R73 did not void extoilet. NA-J used a wet R73's face, back, arms and made no attempts to eathing. NA-J stated R73 used and transferred on her own, ained a stroke a few months ared a mechanical lift for heelchair for mobility and was	F 3	09		

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F 309	ago (R73) developed facility attempted to message on her prin condition. The number of the stroke and wanted not tell her she had FM-A stated she di until several hours facility back, they hospital for these stold staff to send R treatment immedia had stroke symptor right away. FM-A the facility did not shospital, adding shwaited too long to sroom for treatment R73's undated Resfamily member (FM contact, responsible a change in conditionation indicated FM-B was Review of R73's Presustaining Treatments by R73's certified or intubated (DNR/labeled, "Goals of to be implemented breathing," and ide Care," with several in accordance with box to check or not	FM-A stated a few months ed stroke symptoms and the o call her, however, just left a none about her sudden change ursing home thought she had a her to call them back. They did not been sent the hospital. It do not receive this message later. When she called the ad not sent (R73) to the ymptoms. FM-A stated she 73 to the emergency room for tely and thought if someone ms they should have gone in stated she was unaware why send her immediately to the e was upset. The facility send (R73) to the emergency e party and the person to call if on. Further, the sheet indicated 1)-A was R73's emergency e party and the person to call if on. Further, the sheet is the secondary contact. Fovider Order for Life ent (POLST) dated and signed turse practitioner (CNP)-A on R73 had do not resuscitated DNI) on the POLST. A section freatment," included directions if R73, "has pulse and/or is ntified R73 had "Comfort options that could be selected R73's wishes. There was a check next to each of these ir wishes of comfort care. The	F3	309			

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F 309	- "Avoid calling 911 instead," - "If possible, do no department]," an - "If possible, do no ER" However, all of thes unchecked, identify implemented. Furth option that was che Interventions and T which was describe aimed at treatment injury or non-life thr further identifying, "The POLST was sigundated. R73's progress not indicated, "Noted [F before dinner at 16 unsteady gait, RT [I non-reactive, slurre hand/foot strength BP [blood pressure [respiration rate] 18 blood] 97% on RA [96.7. Family notifier resident sent into the A First Light Health dated 6/10/17, indicated for the primary in th	t transport to ER [emergency d, t admit to the hospital from the se options were left ring R73 wanted these actions her, R73's POLST identified an ecked which identified, "Limit reat Reversible Conditions," and as, "Provide interventions of new or reversible illness / reatening chronic conditions," Transport to ER presumed." If gned by R73, however, was edated 6/10/17, at 18:23 R73] was difficult to rouse 15. Noted resident with right] facial droop, RT pupil d/slow speech, and bilateral WNL [with in normal limits]. In 149/52, P [pulse] 73, RR and S, Sp 02 [oxygen saturation in room air] and T [temperature] and writer at 1815 that they want he hospital to get checked out." System Ambulance Report cated dispatch was called at ary impression was R73 arrived at the hospital on a ambulance, 2 hours and 35 a significant change in ified at the nursing home.		09			

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F 309	identified R73 had (stroke). The report old female with a homeningioma (non-offrom the membrane of CVA's, DM (diable (high cholesterol), ladmitted with probate primary deficit difficulty and will confor secondary preventher apy were order the report indicated was done and composed on 10/00 CSF (cerebral spin hydrocephalus (flui away). The CT seacute intracranial and chronic small vesses blood) change, staticerebellar meninging lobe infarct (stroke to Hosp-Admission admitted to the hose A First Light Health Summary dated 6/doctor (MD)-A indicated (Fwith history of dem MD, hyperlipidemiato the ER with increwith speech. Lives due to dementia. It treatment for conditional conditions are successive to dementia. It treatment for conditional conditions are successive to dementia. It treatment for conditional conditions are successive to dementia. It treatment for conditional conditions are successive to dementia. It treatment for conditions are successive to dementia.	oort dated 6/10/17, at 6:49 p.m. a primary diagnosis of CVA rt indicated she was a 75 year	F3	09		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	noted a change. It once family was co (POLST listed com treatment for poter that time, too muck known normal time activator that is iso dissolves the clot a part of the brain de an option. Pt has shistory and exam of (fevers/chills), chebreath), cough or to (unclear how reliable A First Light Health Physician Criteria last revised 2/11/10 Inclusion Criteria: -Clearly defined tin-tPA can be given onset -Patients over 18 -The patient's symwith acute ischemic deficit A Senior Care Trait dated 6/15/17, con practitioner (CNP)-long term care visit was acute CVA. Tillness) on the repoold female with particular deficit.	age 35 and once she was awake staff took time to contact family and ontacted pt was brought to ER afort care but family wanted intially reversible condition). By in time had passed from the last is so tPA (tissue plasminogen hemic stroke treatment that and improves blood flow to the eprived of blood flow) was not significant dementia making difficult. Denies any f/c ist pain, sob (shortness of rouble going to the bathroom ole pt is.) no other concerns. In System Mora, Minnesota for tPA Use In Stroke guidelines on, indicated the following the of onset of symptoms within 3 hours of symptoms within 3 hours of symptom ptoms are clearly consistent to stroke with measurable Insitions Long Term Care Visit inpleted by certified nurse of and her primary diagnosis the HPI (history of present out indicated she was seen for a thand her primary diagnosis the HPI (history of present out indicated she was a "75 year at medical history significant for with right side weakness, meningioma and hypertension. 17 and laid down for nap. she had increased confusion,	F3	609			

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	PROVIDER OR SUPPLIER RE LIVING COMMUNI	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 309	brought to ED for ean acute CVA. She Clare on 6/12/17. in speech, difficulty confusion. She is a honey thickened lid bound, gait and ba indicated R73 return following an acute cognition, speech a made to PT/OT/SL changed to honey-A Speech Therapy Assessment dated indicated R73 was receptive aphasia. prior level of command able to unders structured convers unfamiliar commun level of communicated maximum maximal cues, was directions and respondent of the CVA and after the independence (assented), currently guard assist (contaunsteadiness)transfers she wented	difficulty speaking. She was evaluation and felt to have had evaluation and felt to have had evaluation and felt to have had evaluation and returned to St. She continues to have deficits a swallowing and increased on mechanical soft diet with quids. She is wheelchair lance unstable." The report med to the nursing home CVA, with primary deficits in and swallow and referrals were P. R73 also had a diet thick liquids, mechanical soft. Plan Of Care Initial 6/14/17, completed by ST-A seen for expressive and The assessment indicated her nunication was minimal assist tand communication in a ations with both familiar and nication partners. Her current ation had changed and she assistance with consistent, able to follow simple bond to simple yes and no a linitial Assessment dated if by PT-A indicated that prior to the following deficits were	F3	309			

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING		30	3/31/2017	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	falls The assessment futo ambulate 100 ft of front wheeled walked of goal status indicated prices and for complete functional An Occupational TI Discharge Summar OT-A indicated prices are up assist with shygiene, partial to rather than the assessment in on 6/26/17, R73 no verbal cues with earn with toileting. During interview 8/3 nurse (RN)-B state and MDS coordinates FM-A wanted to mate to (R73) that was reference to form the should have be department right as that FM-A would was staff should not have the complete the poon stated (F) her stroke, and fee a wheelchair and so DON further stated	in moderate risk to high risk of arther indicated R73's goal was with contact guard assist and er with right neglect. The end ated her goal was not met and tes 100 ft with minimal int wheeled walker in order to		09			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245291	B. WING _		08/	31/2017
	NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		- · · - · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	for FM-A to call the unaware of the ED it was "too late" to the she was not sent in home. On 8/30/17, at 12:2 with MD-A (who was at First Light Health hospital discharge did not return the puring interview 8/3 stated LPN-C was and was R73's nursepoke to LPN-C and waited for the familial sending her in was (CNP)-A told him to wanted to do first. remember if he concontact. During interview 8/3 stated on 6/10/17, the symptoms R73 based on past convolution only wanted things and wanted (R73) sinfection and if it was didn't want her sen (R73) had a brain to pain. FM-A was not they would not wan having stroke symperm-A was upset the away, and stated, "	facility back, and was discharge summary identifying treat (R73) with tPA because a right away by the nursing 20 p.m. a message was left as not her primary physician) a System who completed the summary on 6/12/17. MD-A	F 30	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245291	B. WING _		08.	/31/2017	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	facility medical dir primary physician) hospitalization on director stated if a hers and was havi should have been right away and no call. The medical pneumonia or son they could have w reviewed the eme stated MD-B was "Reading MD-B no you have to assun had no CVA symp they decided not t time had passed. stroke could be a would make sense away." During interview 8 stated during an e expect the facility practitioner, and facontact the primar secondary contact in. The DON state for the family to casent her in. The D specific policy state protocol. During interview 8	age 39 /31/17, at 10:46 a.m. with the ector (who was not R73's reviewed R73's POLST and 6/10/17. The facility medical resident has a POLST like ng stroke symptoms she sent to the emergency room a wait for family to return the director stated if she had nething that was not so urgent aited. The medical director regency department note and the emergency room physician. The state of the ED reat with tPA because too much the medical director stated a reversible condition and it to send her to the ED right /31/17, at 11:19 a.m. the DON mergency situation she would to call the physician or nurse amily. If they were unable to y contact, they should call the and then just send the resident of they should not have waited all back and should have just ON stated they don't have a ing this but this was their	F 30				
	she woke up he n	3's nurse on 6/10/17, and when obted a facial droop and lled the CNP-A, who told him					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING		(08/31/2017	
	PROVIDER OR SUPPLIER RE LIVING COMMUNI	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP COE 110 NORTH 7TH STREET MORA, MN 55051)E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 309	to the ED because LPN-C stated he camessage. When FN LPN-C to send her he was unable to re FM-A, but had not and was unsure if his secondary contact though so much time heard from FM-A neagain about not being because CNP-A did On 8/31/17, at 1:12 ED and a message not return the call. During interview 8/3 stated she can not 6/10/17, about not 1 FM-A or FM-B right LPN-C called me and changed her decisi impression FM-A did During interview 8/3 p.m. NA-B stated pneed much assistated in high pression FM-A did not predict the staff but pushing refrom activities and requested, was har stated, "Since her subrushes off converse knows life is now did not requested to send the converse shows life is now did not requested."	lege 40 e family would want her to go of her diagnosis or something. Alled (FM)-A and left a M-A called back she told in right away. LPN-C stated exall the events after calling received a call back right away he attempted to call the FM-B. LPN-C stated even he had passed, he had not for did he recall calling CNP-A ng able to reach FM-A, d not seem too concerned. The p.m. a call was placed to the was left for MD-B. MD-B did 131/17, at 1:33 p.m. CNP-A recall if LPN-C called her on being able to reach (R73's) away. CNP-A stated even if gain, she would not have not on because she was under the did not want to treat (R73). 131/17, at approximately 2:45 rior to R73's stroke she did not not from staff to brush her and dress and undress herself. I she fed herself and knew the es, would voluntarily assist sident wheel chairs to and meals when residents opy and joked around. NA-B stroke she seems sad, down, sations and it seems that she different." NA-B further stated, mbarrassed, while [R73]	F3	309			

ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		08	/31/2017
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	with care, [R73's] edoesn't like it." During interview 8/5 p.m. NA-C after R7 sad. NA-C stated the dressed and groom assist to tuck in a bistroke, R73 needs daily needs. During interview 8/5 stated the facility can be a message. The was (R73's) second Although R73 had 6/10/17, with stroke to provide prompt of sending R73 imme R73's POLST, which treatment for reverse failure to respond in R73 from receiving sensitive and must hours to reverse stand receiving this man significant change dependent upon standing R73. A facility policy Change of the facility must contimediately and not mediately and n	and when she is assisted expressions appears that she all 17, at approximately 3:00 and the stroke she seems more not prior to the stroke R73 and herself with occasional allouse. NA-C stated since the total assistance with all her alled her on 6/10/17, and left a facility did not call FM-B who dary emergency contact. If a change in condition on a symptoms, the facility failed emergency treatment by not diately to the ED following the outlined R73's wanted sible conditions. The facility's a timely manner, prevented tPA medication, which is time be administered within 3 roke symptoms. As a result of the edication, R73 had a fin her ADL's and was aff, resulting in actual harm to a sident's legal representative or esident's legal representative or sident's legal representative or	F 3	09		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		245291	B. WING			08/	31/2017
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				110	REET ADDRESS, CITY, STATE, ZIP CODE NORTH 7TH STREET DRA, MN 55051	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	change in resident' psychosocial status significantly. c) A de the resident from the indicated to notify the when there is a character of the resident from the indicated to notify the when there is a character of the individual, the resident formula individual, the resident formula indicated licensed in psychological formula indicated licensed in psychological status significantly.	ge 42 s physical, mental or s. b) A need to alter treatment ecision to transfer or discharge ne facility." The policy further ne family significant other ange in status of a resident, the ll: 1. Notify the first person 2. If unable to locate next designated individual will ergency Care undated nursing staff will provide care emergency situation and the	F3	09			
	procedure would be 911 would be called problem and do no And in a non-life the emergency care, no for ambulance and A facility policy St. Mora Policy and Pr Guidelines And Ma Record dated 1/20	e to stay with the resident while d, give address, nature of the thang up until told to do so. reatening emergency to give otify physician, if needed call notify family. Clare Living Community Of occedure For Documentation intaining Legally Sound Health 17, indicated under notification					
	resident's physiciar required. When a capacity occurs regars such communication notification) have to and method of all capacity the implementation resident's response machines should be call and does not motification. Make	hat notification to the an unread practitioner or family is discussion with the resident's ding care of the resident, all on (including attempts at a be charted. Include the time communications. The entry orders received or responses, of such orders if any and the elimited to a request to return the definition of sure to report to the the next elimited was left with the family and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	245291		B. WING _		08/31/2017	
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 312 SS=D	A facility policy St. O 3/8/11, indicated unhave a completed F medical record. The based on wishes of representative ager regularly and kept of the nursing staff, phinvolved with the caplan that states the they want to manage This form will address related to the end of they desire while live 483.24(a)(2) ADL ODEPENDENT RES (a)(2) A resident whactivities of daily living services to maintain personal and oral horal than the facility for grooming was proving the facility for grooming was proving the facility for grooming was proving was dependent on services. R73's significant check (MDS) dated 6/21/1 limited assist with personal and cated should be supported to the facility for grooming was proving the fac	Clare Living Community dated der "Policy: Each resident will POLST form included in their is form will be completed the resident and/or appointed at. The form will be revived current. Purpose: To provide aysicians, family and all others are of the resident, a written resident's wishes about how the their treatment and care. Their wishes not only fife, but also the quality of life ing with a chronic illness." ARE PROVIDED FOR IDENTS To is unable to carry out any receives the necessary and good nutrition, grooming, and ygiene. AT is not met as evidenced ion, interview and document ailed to ensure all personal ded to 1 of 3 residents (R73) are of daily living (ADL's) who	F 3		rvices with e. re vised sidents n facial nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245291	B. WING		08/	31/2017	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA			1	STREET ADDRESS, CITY, STATE, ZIP CODE I10 NORTH 7TH STREET MORA, MN 55051		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 312	R73's care plan dawas at risk for poodementia. The carhad impaired active to diagnosis of deas evidence by (Adressing, groomin During observation was observed to be day room with muchin down to the napproximately 3/8 During observation was sitting in her we the doorway with vand chin. During interview 8 medical assistant good with receiving toileting but she we subsequent interview when looking at Food have been of TMA-A stated R73 her bath day. Review of the Bath received her bath During observation a.m. R73 was lying from her chin to the assistant (NA)-J e R73's socks on prince the carbon carbon process.	ated 10/21/15, indicated she or oral hygiene related to be plan further indicated R73 ities of daily living (ADL) related mentia, and cerebral infarction, EB) requires assist with g and hygiene. In on 8/28/17, at 1:20 p.m. R73 are sitting in her wheelchair in the tiple visible facial hairs from her niddle of her neck inch in length. In 8/29/17, at 12:26 p.m. R73 wheelchair in the south hall by visible facial hair on her face In a 8/29/17, at 6:45 p.m. trained (TMA)-A stated R73 is pretty g cares she might say no to gray it allow us to do grooming. In the wat 7:06 p.m. TMA-A stated R73's facial hairs something lone with the facial hairs. It is should have been shaved on the Book indicated that R73	F 312	reviewed by IDT. Direct Care stand members have been trained as to their respective roles and responsibilities regarding the fa hair/shaving policy on 10/12/17 hair/shaving audits will be conditimes per week for 30 days, we day, monthly for 3 months and thereafter with results reported Committee for review and furth recommendation. Further syste and staff education will be provindicated by audits. The Director Nursing or designee will be responded for compliance. Compliance date 10/30/17	cial Facial ucted 3 ekly for 30 randomly to QA er em revision ided if or of		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245291	245291 B. WING		08/31/2017	
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	attached the straps up in a standing po the bathroom, remand lowered her on R73's face, back, a dressed her. NA-J the standing lift and NA-J stated all that NA-J combed R73's hallway. NA-J did nher facial hair. During interview 8/3 director of nursing (be removing facial and it could also be staff noticed it [facial indicated oral care p.m. cares. The DC done when staff go and that she should received oral care. the staff know to should be staff noticed it [facial indicated oral care p.m. cares when staff go and that she should received oral care. The DC done when staff go and that she should receive oral care are swhen I got he completed these care when I was informed stated she completed the staff she completed these care when I was informed stated she completed.	under her arms and lifted her sition. NA-J wheeled the lift to oved R73's incontinent pad to the toilet. NA-J washed rms, legs and peri area and then lifted R73 back up with I lowered into her wheelchair. was left was to comb the hair. shair and wheeled her into the ot provide oral care or shave 80/17, at 11:39 a.m. the (DON) stated the staff should hair as they are doing cares adone during there bath or if all hair]. The DON further should be done with a.m. and DN stated a.m. cares were tresidents up for the morning I have been shaved and The DON stated she would let have her and do oral cares. 80/17, at 1:59 p.m. NA-J brrmed her that R73 did not and was not shaved with a.m. er dressed in the morning. I have after her lunch today and by the DON. NA-J further es these cares after lunch.	F 31	2		
F 412 SS=D			F 41	2		10/30/17
						1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245291		B. WING		08/31/2017	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	35/61/2311	
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
F 412	Continued From pa	ge 46	F 412	2		
	The facility-					
	resource, in accord	or obtain from an outside ance with §483.70(g) of this lental services to meet the dent:				
	(i) Routine dental services (to the extent covered under the State plan); and(ii) Emergency dental services;					
	(b)(2) Must, if nece the resident-	ssary or if requested, assist				
	(i) In making appoi	ntments; and				
	(ii) By arranging for dental services local	transportation to and from the ations;				
	wish to participate to dental services as under the State pla	esidents who are eligible and to apply for reimbursement of an incurred medical expense n. NT is not met as evidenced				
	Based on observareview, the facility freferral was made for 1 of 3 residents	tion, interview and document ailed to ensure a dental to address missing dentures (R90) reviewed for dental		F412 Routine/Emergency Dental Services It is the policy of St. Clare Living		
	hygiene. Findings include:			Community to provide routine and emergency in accordance with each resident plan of care. For resident # care plan reviewed and revised on		
	7/20/17, identified fi impairment and rec	num Data Set (MDS) dated R90 had severe cognitive quired extensive assistance ne. R90's Resident Census		9/27/17. Education has been provide Licensed Nursing and NA/R is staff members regarding dental services emergency dental services on 10/3	f s and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245291		245291	B. WING			08/31/2017	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				110 N	ET ADDRESS, CITY, STATE, ZIP CODE NORTH 7TH STREET RA, MN 55051	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 412	R90's Oral Cavity identified R90 wor with, "Good," fitmed During observation was seated in the television. R90 sr her full lower dent visible natural teet the upper palate. Where her upper control teet her upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station asked about her teet to did not have any upper palate station.	Assessment dated 7/19/17, e full upper and lower dentures ent. In on 8/28/17, at 3:00 p.m. R90 commons area watching miled at the surveyor showing ure, however, did not have any the or denture appliance(s) on R90 stated she was not sure lenture was and was unable to be upper teeth had been commenting she, "did have all ne point. It observation on 8/30/17, at a seated in the dining room ast and hot cereal. R90 again, risible teeth or dentures on her neeth. R90 denied having any and consumed nearly 100% of the dated 8/9/17, identified es not located this [morning]. his [morning] at 0730." No in the missing dentures was	F 4	a d p m 9 e re a m ra w a	nd 10/12/17. For all residents with entures who may be affected by ractice an audit for ill fitting, broken issing dentures was completed /29/17. The policy for dental services has been been been been been been been bee	this en, or on vices and een nture or one npliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245291	B. WING			08/:	31/2017
	PROVIDER OR SUPPLIER RE LIVING COMMUNI	TY OF MORA		11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 7TH STREET IORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 412	wore, "top and both top set had been mow." NA-D stated addressed it with facan get to a dentist. During interview on stated R90 had, "faconly had, "the botto was unsure where or how long they had NA-E stated license aware they were mover they were moved they were mover they were mover they were mover they were mover	NA)-D stated R90 typically om," dentures, however, the issing, "[a] little over a month she thought nursing had amily and were, "seeing if they." 8/30/17, at 8:19 a.m. NA-E lise teeth," however currently mones." NA-E stated she the upper set of dentures was, ad been missing. Further, ed practical nurse (LPN)-A was	F 4	.12			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, 2 110 NORTH 7TH STREET MORA, MN 55051	ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 412	A facility Denture C dated 11/7/16, iden "Procedure for Rep Damaged or Missin staff to report the manager. Further,	are and Replacement policy tified a section labeled, porting and Addressing and Dentures," and directed hissing dentures to the nurse the policy directed, "within 3 ould refer the resident for	F 4	.12				

F5 a91025

PRINTED: 10/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED Albuilding 01 - MAIN BUILDING 01 245291 B. WING 08/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET ST CLARE LIVING COMMUNITY OF MORA MORA, MN 55051 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Electronically Signed

Event ID: NVD021

Facility ID: 00814

09/29/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245291	B. WING		08	/31/2017	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP COD 110 NORTH 7TH STREET MORA, MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	Continued From pa By e-mail to both: Marian.Whitney@s and Angela.Kappenmai	tate.mn.us	K 04	00			
	DEFICIENCY MUS FOLLOWING INFO	T INCLUDE ALL OF THE DRMATION: what has been, or will be, done					
	3. The name and/o responsible for corr	oposed, completion date. r title of the person rection and monitoring to ence of the deficiency					
	building with small building was constructed in 1999 II(111) construction V(111) construction type V(111) assiste is separated by 2 h minute rated, self of Type V(111) constructions	mmunity of Mora is a 1-story partial basement. The original fucted in 1969 and additions 9. The 1969 building is of type and the 1999 building is type and the north a single story d living facility also adjoins and our construction with a 90 losing door. The addition of uction opened to the west in rivey separately can now be ailding.					
	facility has a compl smoke detection in	sprinkler protected. The ete fire alarm system with the corridors and spaces r, that is monitored for rtment notification.					

PRINTED: 10/03/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 245291 B. WING 08/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET ST CLARE LIVING COMMUNITY OF MORA MORA, MN 55051 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 Continued From page 2 K 000 The facility has a licensed capacity of 65 beds and had a census of 56 at the time of the inspection. The requirement at 42 CFR Subpart 483.70(a) is NOT MET. NFPA 101 Smoke Detection 10/30/17 K 347 K 347 SS=D **Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is not met as evidenced by: K347 NFPA 101 Smoke Detection Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code, St. Clare Living Community of Mora does (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 comply with the NFPA 101 Smoke National Fire Alarm Code (2010) section Detection under the 2012 Existing 17.6.3.1.1 This deficient practice could affect the Building requirements. During the tour with the Fire Marshall on 8/31/17 the ability of the alarm system to sound in a timely manner during a fire event which could affect 10 Elevator Mechanical Room was of the 65 residents and an undetermined amount inspected. It was noted that there was no of staff and visitors. Smoke Detection located within the mechanical room. Findings include: The Administrator has scheduled with the On the facility tour between 8:00 am to 1:00 pm Summit Company to add to our detection on 08/31/2017, observation and staff interview system one smoke detector and one revealed no smoke detector in the Elevator sprinkler head in compliance with the Mechanical Room. NFPA 101 Life Safety Code (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 National This deficient condition was confirmed by the Fire Alarm Code (2010) section 17.6.3.1.1 Facility Administrator and the Environmental no later than October 30, 2017. Services Supervisor. The Administrator will be responsible for ongoing compliance with NFPA 101 Life Safety Code (2012) and PFPA 72 National

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY PLETED	
245291			B. WING _		08/31/2017		
	PROVIDER OR SUPPLIER	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	,		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	.D BE	(X5) COMPLETION DATE	
K 347	Continued From pa	ge 3	K 34	Fire Alarm Code (2010). The corn of this deficiency will be reported to QA committee at their October 20 Meeting.	to the		
K 351 SS=F		r System - Installation	K 35	Date of Correction: 10/30/17		10/30/17	
	construction type, a approved automatic accordance with Ni Installation of Sprin In Type I and II con measures are perm sprinkler protection or local regulations In hospitals, sprinkl closets of patient sl of the closet does r sprinkler coverage required by NFPA 1 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 This STANDARD is Based on observate facility failed to instance with the Safety Code (NFPA 9.7.1.1 and the 201 Standard for the Instance of the Instance	d hospitals where required by an exprinkler system in FPA 13, Standard for the kler Systems. struction, alternative protection nitted to be substituted for in specific areas where state prohibit sprinklers. ers are not required in clothes eeping rooms where the area not exceed 6 square feet and covers the closet footprint as 3, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5,		K351 NFPA 101 Sprinkler System Installation St. Clare Living Community of Mocomply with the NFPA 101 Smoke Detection under the 2012 Existing Building requirements. During the with the Fire Marshall on 8/31/17 Elevator Mechanical Room was inspected. It was noted that there	ra does e l e tour the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
245291		B. WING	B. WING			31/2017	
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 7TH STREET IORA, MN 55051		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 351	on 08/31/2017, observed the Elevator Mechanism This deficient conditions	between 8:00 am to 1:00 pm servations and staff interview s no sprinkler head installed in anical Room. dition was confirmed by the tor and the Environmental	K	351	sprinkler head located within the room The Administrator has scheduled we Summit Company to add to our det system one smoke detector and on sprinkler head in compliance with the NFPA 101 Life Safety Code (2012) 19.3.6.1 & 9.6.2.10 and NFPA 72 Now Fire Alarm Code (2010) section 17. In later than October 30, 2017. The Administrator will be responsibe ongoing compliance with NFPA 101 Safety Code (2012) and PFPA 72 Now Fire Alarm Code (2010). The corresponding to this deficiency will be reported to QA committee at their October 2011 Meeting.	ith the ection e section ational 6.3.1.1 le for Life lational ction the	
	Sprinkler System - Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspendintained in a sec available.		K	853	Date of Correction: 10/30/17		9/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245291	B. WING _	11-12	08/	31/2017
	PROVIDER OR SUPPLIER RE LIVING COMMUNI	TY OF MORA		STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE
K 353	any non-required of system. 9.7.5, 9.7.7, 9.7.8, This STANDARD is Based on a review interview with staff, Sprinkler Suppress accordance with NI (edition 2012), Sprinkler Suppress accordance with NI (edition 2012), Sprinkler Suppress accordance with NI (edition 2012), Sprinkler Sprinkler inspected, tested, awith NI PA 25, Start Testing, and Mainta Protection Systems information on cover partial automatic sprinkler automatic sprinkler automatic sprinkler safety of staff and visitors Findings Include: During documentation and 1:00 PM on 08 review and staff interprinkler test was prinkler test was prinkler test was prinkler completed. This deficient conditions	KS information on coverage for r partial automatic sprinkler and NFPA 25 s not met as evidenced by: of documentation and an it was determined that the ion system is not in FPA 101 The Life Safety Code nkler System - Maintenance and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire and Provide in REMARKS erage for any non-required or prinkler system. 9.7.5, 9.7.7, i. This deficient practice of an undetermined amount ion review between 8:00 AM //31/2017, documentation erview revealed the last performed 07/18/2016 and 3 of akler inspections were not stion was confirmed by the or and the Environmental	K 35	K353 NFPA 101 Sprinkler System Maintenance and Testing At St. Clare Living Community of M Sprinkler Systems ☐ Maintenance Testing are conducted in accordan NFPA 25, Standard for the Inspectitesting, and maintaining of Water-k Fire Protection System. We maint standard documentation of type of and/or maintenance of the system. 8/31/17 during the tour of the facilit Fire Marshall noticed that the last a inspection was conducted on 7/18/ and that there was no documentation of 4 quarterly flow test. The Administrator had contacted the Summit Company on 8/31/17 to so the annual inspection. This inspection and has trained St. Clar new Environmental Service Director the correct procedures for doing the quarterly inspection going forward. The Administrator will be responsite on-going monitoring for compliance NFPA 101 Sprinkler System ☐ Maintenance and Testing. The coof this deficiency will be reported to QA committee at their October 201 Meeting.	flora and ce with ion, based ain test. On ty the annual 2016 ion for 3 in echedule tion ummit arterly to a control of the with a control of the control of t	

OLITICI	TO TOTA MILDIOMINE	A MILDIO/ ND OLIVIOLO			01112 113	. 0000 000	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED	
		245291	B. WING		08/	31/2017	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA				STREET ADDRESS, CITY, STATE, ZIP CO 110 NORTH 7TH STREET MORA, MN 55051		00/31/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 353	Continued From pa	age 6	К3	53			
K 901 SS=D		entals - Building System	K 9	Date Corrected: 9/22/17		10/27/17	
	Building systems at 1 through 4 require Categories are dete						
	This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 8:00 AM and 1:00 PM on 08/31/2017, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the			K901 NFPA 101 Fundame Building System Categories Fundamentals □ Building System designed to meet Category 1 requirements as detailed in Nupon review on 8/31/17 the documentation that an approach Building Risk Assessment was to meet the Category 1 throur requirements as detailed in Number 1 St. Clare Living Community of the process of conducting a assessment designed to mee	stem ns are I through 4 NFPA 99. facility lacked opriate as completed igh 4 NFPA 99. of Mora is in building risk		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245291	B. WING			08/31/2017	
	PROVIDER OR SUPPLIER	TY OF MORA		1.	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 7TH STREET 10RA, MN 55051	*	
(X4) ID PREFIX T A G	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
K 901	Continued From pa	ge 7	K	901	annually in October of each year. The Administrator will be responsible on-going monitoring for compliance NFPA 99 requirements to meet Cath-4. The correction of this deficient be reported to the QA committee at October 2017 Meeting. Date corrected: 10/27/17	e with egory cy will	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 20, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5291026

Dear Mr. L'Heureux:

The above facility was surveyed on August 28, 2017 through August 31, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

St. Clare Living Community of Mora September 20, 2017 Page 2

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fisher, Unit Supervisor at (320) 223-7338 or brenda.fischer@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

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

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/31/2	2017
	PROVIDER OR SUPPLIER	110 NORT	TH 7TH STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE ((X5) COMPLETE DATE
2 000	2 000 Initial Comments					
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the matter of t	nether a violation has been				
	When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/02/17 **Electronically Signed**

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00814	B. WING		08/3	1/2017
	PROVIDER OR SUPPLIER	110 NORT	H 7TH STRE	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to electronic Department the above provider orders are issued. electronic plan of coreviewed these ord they will be complemented by the State Licensing federal software. The state state is the "Summer column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Corection or Federal Software Suggested Time period for Corection Federal Software S	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. In the following correction Please indicate in your orrection that you have ers, and identify the date when ted. In the following correction Orders using ag numbers have been ota state statutes/rules for the assigned tag number eff column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and trection. IRD THE HEADING OF THE	2 000			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) D			
			A. BOILDING	•		
		00814	B. WING		08/3	31/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	I Y OF MORA	RTH 7TH STR MN 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	age 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		F			
2 565	5 MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			10/30/17
		omprehensive plan of care Il personnel involved in the t.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete grooming as directed by the care plan for 1 of 3 residents (R73) reviewed for activities of daily living (ADLs).			Correction Completed		
	Findings include:					
	(MDS) dated 6/21/1 limited assist with p further indicated sh	nange Minimum Data Set 17, identified R73 needed personal hygiene. The MDS ne was endtulous and needed e for personal hygiene.	ı			
	was at risk for poor dementia. The cal had impaired activi to diagnosis of dem	ted 10/21/15, indicated she r oral hygiene related to re plan further indicated R73 ties of daily living (ADL) relat- nentia, and cerebral infarction EB) requires assist with g and hygiene.				
		on 8/28/17, at 1:20 p.m. R73 e sitting in her wheelchair in t				

Minnesota Department of Health

STATE FORM 6899 NVD011 If continuation sheet 3 of 30

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/	31/2017
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY, S			
ST CLAF	RE LIVING COMMUNIT	TY OF MORA	ORTH 7TH STRE A, MN 55051	:EI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
	chin down to the mi approximately 3/8 in During observation was sitting in her withe doorway with visand chin. During interview 8/2 medical assistant (good with receiving toileting but she will subsequent intervie looking at R73's facts something that coushould have been sher bath day."		y / n ed			
	a.m. R73 was lying from her chin to the assistant (NA)-J en R73's socks on proshe brought a standattached the straps proceeded to lift he the lift. NA-J then whathroom removed lowered her onto the to wash her face, be area and dressed hup with the standing wheelchair. NA-J the onow is comb you hair and then whee	and interview 8/30/17, at 9: in bed with visible facial has middle of her neck. Nursing tered the room. NA-J put beceded to sit R73 up in bedding lift to her bed and a under her arms and ar up in a standing position wheeled the lift to the her incontinent pad and are toilet. NA-J then proceed ack arms and legs and periner. NA-J then lifted R73 barg lift and lowered into her hen stated all we have left the ur hair. NA-J combed R73's led her into the hallway. NA-care or shave her facial ha	ir ng vith led ack o s A-J			

Minnesota Department of Health

STATE FORM 6899 NVD011 If continuation sheet 4 of 30

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/31/2017	
	PROVIDER OR SUPPLIER	110 NOR	TH 7TH STRE	ETATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	During interview 8/3 director of nursing be removing facial and it could also be they notice it. The care should be don The DON stated a. residents up for the have been shaved DON stated she will her and do oral care. During interview 8/3 stated the DON information of the completed these can be completed these can be completed these can be completed she completed stated she completed these can be completed these can be completed these can be completed stated she completed stated she completed these can be completed these can be completed stated she completed stated she completed these can be completed these can be completed stated she completed stated she completed these can be completed these can be completed stated she completed stated she completed these can be compl	30/17, at 11:39 a.m. the (DON) stated the staff should hair as they are doing cares done during there bath or if DON further indicated oral e with a.m. and p.m. cares. m. cares is when they get the morning and that she should and received oral care. The let the staff know to shave	2 565			
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	of daily living. Based on the ident assessment, a nursing that: is unable to carry out ing receives the necessary in good nutrition, grooming,	2 920			10/30/17

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/3	1/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST CLAF	RE LIVING COMMUNI	TY OF MORA MORA, M	TH 7TH STRI N 55051	=E I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 920	Continued From pa	ge 5	2 920				
	and personal and o	ral hygiene.					
	by: Based on observat review, the facility f grooming was prov	ent is not met as evidenced ion, interview and document ailed to ensure all personal ided to 1 of 3 residents (R73) es of daily living (ADL's) who staff for cares.		Correction Completed			
	Findings include:						
	R73's significant change Minimum Data Set (MDS) dated 6/21/17, identified R73 needed limited assist with personal hygiene. The MDS further indicated she was endtulous and needed limited assist of one for personal hygiene.						
	R73's care plan dated 10/21/15, indicated she was at risk for poor oral hygiene related to dementia. The care plan further indicated R73 had impaired activities of daily living (ADL) related to diagnosis of dementia, and cerebral infarction, as evidence by (AEB) requires assist with dressing, grooming and hygiene.						
	was observed to be						
	was sitting in her w	8/29/17, at 12:26 p.m. R73 heelchair in the south hall by sible facial hair on her face					
		29/17, at 6:45 p.m. trained TMA)-A stated R73 is pretty					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/	31/2017
	PROVIDER OR SUPPLIER	TY OF MORA 110 NOF	DDRESS, CITY, STREMN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	good with receiving toileting but she will subsequent interviewhen looking at R7 could have been do TMA-A stated R73 her bath day. Review of the Bath received her bath on During observation a.m. R73 was lying from her chin to the assistant (NA)-J en R73's socks on promattached the straps up in a standing pothe bathroom, remaind lowered her on R73's face, back, a dressed her. NA-J the standing lift and NA-J stated all that NA-J combed R73's	cares she might say no to I allow us to do grooming. In the wat 7:06 p.m. TMA-A stated 73's facial hairs something one with the facial hairs. Should have been shaved on Book indicated that R73				
	director of nursing (be removing facial and it could also be staff noticed it [facial indicated oral care p.m. cares. The DC done when staff go and that she should received oral care.	30/17, at 11:39 a.m. the (DON) stated the staff should hair as they are doing cares done during there bath or if al hair]. The DON further should be done with a.m. and DN stated a.m. cares were tresidents up for the morning have been shaved and The DON stated she would leave her and do oral cares.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00814	B. WING		08/3	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	'H 7TH STRE N 55051	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	age 7	2 920			
	stated the DON inforeceive oral care and cares when I got he completed these can when I was informed stated she completed. A facility policy was received. SUGGESTED MET The director of nursinservice staff regar	30/17, at 1:59 p.m. NA-J ormed her that R73 did not and was not shaved with a.m. or dressed in the morning. I have after her lunch today and by the DON. NA-J further ses these cares after lunch. THOD OF CORRECTION: sing (DON) or designee could right red to ensure				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21325	MN Rule 4658.072 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325			10/30/17
	home must provide resource, routine de needs of each reside include dental examples and crowns, oral surgery, bridge orthodontic procede that are provided for	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services minations and cleanings, root canals, periodontal care, es and removable dentures, ures, and adjunctive services or similar dental patients in the e, as limited by third party icies.				
	by:	ent is not met as evidenced ion, interview and document		Correction Completed		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00814	B. WING		08/3	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, M	'H 7TH STRE N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	Continued From pa	ige 8	21325			
	review, the facility failed to ensure a dental referral was made to address missing dentures for 1 of 3 residents (R90) reviewed for dental hygiene.					
	Findings include:					
	R90's annual Minimum Data Set (MDS) dated 7/20/17, identified R90 had severe cognitive impairment and required extensive assistance with personal hygiene. R90's Resident Census sheet dated 8/31/17, identified R90's payer source to be Medicaid. R90's Oral Cavity Assessment dated 7/19/17, identified R90 wore full upper and lower dentures					
	with, "Good," fitment. During observation on 8/28/17, at 3:00 p.m. R90 was seated in the commons area watching television. R90 smiled at the surveyor showing her full lower denture, however, did not have any visible natural teeth or denture appliance(s) on the upper palate. R90 stated she was not sure where her upper denture was and was unable to recall how long her upper teeth had been missing, merely commenting she, "did have all [her] teeth," at some point. During subsequent observation on 8/30/17, at					
	eating buttered toadid not have any visupper palate stating asked about her tentrouble chewing, arthe meal. R90's progress not	seated in the dining room st and hot cereal. R90 again, sible teeth or dentures on her g, "my top one's not [in]," when eth. R90 denied having any nd consumed nearly 100% of e dated 8/9/17, identified is not located this [morning].				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		00814	B. WING		08/3	1/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA MORA, M	TH 7TH STRE N 55051	:EI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 9	21325			
	laundry updated this [morning] at 0730." No further follow up on the missing dentures was identified in R90's progress note(s).					
	R90's medical record was reviewed and lacked any follow-up or service plan for R90's missing upper dentures identified on the progress note dated 8/9/17.					
	nursing assistant (N wore, "top and botto top set had been m now." NA-D stated	on 8/30/17, at 8:06 a.m. NA)-D stated R90 typically om," dentures, however, the issing, "[a] little over a month she thought nursing had amily and were, "seeing if they ."				
	During interview on 8/30/17, at 8:19 a.m. NA-E stated R90 had, "false teeth," however currently only had, "the bottom ones." NA-E stated she was unsure where the upper set of dentures was, or how long they had been missing. Further, NA-E stated licensed practical nurse (LPN)-A was aware they were missing.					
	stated she thought missing, "for a mon as, "somebody's careviewed R90's me lacked any follow u wanted to proceed she would contact to subsequent intervieus LPN-A stated she sparty who voiced the yet," on R90's missing responsible party who rew dentures to	on 8/30/17, at 9:15 a.m. LPN-A R90's upper denture had been th now," and family was aware alled family about this." LPN-A dical record and stated it p or direction on how family with the missing dentures, so the responsible party. During aw on 8/30/17, at 12:39 p.m. spoke with R90's responsible tey, "had not been updated ing teeth. LPN-A stated R90's ranted her seen by the dentist be cast. LPN-A added she thad not been addressed				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/3	1/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	E LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	H 7TH STRE N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 10	21325			
	prior, "I don't know	why it wasn't followed up on."				
	director of nursing (should be reported start the process fo adding R90's dentu	8/31/17, at 9:13 a.m. the (DON) stated missing dentures to the family so staff could regetting new ones made tres should have been ey were first identified to be				
	dated 11/7/16, iden "Procedure for Rep Damaged or Missin staff to report the manager. Further,	are and Replacement policy tified a section labeled, orting and Addressing ag Dentures," and directed hissing dentures to the nurse the policy directed, "within 3 ould refer the resident for				
	The director of nurs inservice staff rega	THOD OF CORRECTION: sing (DON) or designee could rding timely follow up with liances, then audit to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			10/30/17
	residents shall have medical and persor needs. Appropriate care designed to er	riate health care. Patients and e the right to appropriate nal care based on individual e care for residents means nable residents to achieve their sical and mental functioning.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/3	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	H 7TH STRI	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From page 11		21810			
		where the service is not blic or private resources.				
	by: Based on observation review, the facility for the emergency medica (R73) who had strought stroke which cause limited R73's ability	ent is not met as evidenced on, interview and document ailed to provide timely I services for 1 of 1 residents ke symptoms and subsequent d physical impairment that to complete activities of daily resulted in actual harm.		Correction Completed		
	Findings include:					
	6/1/17, indicated s impaired, needed s assistance of one f (ADLs), she needed and physical assist	imum Data Set (MDS) dated he was severely cognitively taff supervision with or activities of daily living d set up assistance with eating ance of one for bathing. There ations of R73's ADL's during briod.				
	identified the follow daily living (ADL) st assistance of one was dressing and toiletindicated she was toileting, ambulated needed staff superwith eating. R73 research	range MDS dated 6/21/17, ing changes in her activity of atus: She now needed limited with bed mobility, transfers, ng. In addition, the MDS otally dependent upon staff for I only once or twice and vision and assistance of one mained severely cognitively is the same on 6/1/17.				
	Assessment (CAA)	Cognitive Care Area dated 6/21/17, identified R73 severely impaired decision				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER: A SUBMOS A S	winnesc	ta Department of He	eaitn					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH TH STREET MORA, MN 55051 SIMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE PRECEDED BY PULL PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET PROVIDER'S PLAN OF CORRECTION PREFEX TAG CONTINUED FOR THE STREET MORA, MN 55051 DEPOVIDER'S PLAN OF CORRECTION PREFEX TAG CROSS-REFERENCED TO THE STREET DATE PREFEX TAG CROSS-REFERENCED TO THE STREET CROSS-REFERENCED TO THE STREET CROSS-REFERENCED TO THE STREET DATE TAG CONTINUED FOR THE STREET MORA, MN 55051 TAG PROVIDER'S PLAN OF CORRECTION PREFEX TAG CROSS-REFERENCED TO THE STREET TAG CROSS-REFERENCED TO THE STREET CROSS-REFERENCED TO THE STREET CROSS-REFERENCED TO THE STREET TAG CROSS-REFERENCED TO THE STREET CROSS-REFERENCED TO THE STREET TAG CROSS-REFERENCED TO THE STREET								
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ST CLARE LIVING COMMUNITY OF MORA 110 NORTH THI STREET MORA, MN 55051			00814		B. WING		08/3	1/2017
CALL LIVING COMMONITY OF MORA MORA, MN 55051	NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES FACAL DEFICIENCIES FACAL DEFICIENCY MUST BE PRECEDED BY FULL PREFIX FACAL DEFICIENCY MUST BE PRECEDED BY FULL PREFIX FACAL DEFICIENCY OR ISS (DEMTEPTING INFOMMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	ST CLAF	RELIVING COMMUNI	TV OF MORA	110 NORT	TH 7TH STRE	EET		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉSIX TAG Continued From page 12 making, which was the same as the 9/22/16, Cognitive CAA. However, now R73 required, "increased help since return from hospital with [stroke]." The following new care areas triggered as a result of changes on her 6/21/17 MDS. R73's Visual Frunction CAA dated 6/26/17, indicated R73 had a change in vision function and now had right field cut vision related to recent CVA (cerebral vascular accident) or (stroke) and used a wheelchair for mobility and she got caught on other's wheelchair wheels when in congested areas. R73's Communication CAA triggered due to recent CVA with a language deficit resident received speech for expressive and receptive aphasia and staff need to assist the resident in finding the correct words for communication. The communication CAA further indicated R73 gets frustrated when unable to find the correct words. The urinary incontinence CAA identified now R73 was occasionally incontinent of urine and needed assistance with tolieting and was on a tolieting plan every two hours and as needed. The urinary incontinence CAA further indicated due to altered communication R73 was at greater risk for incontinence. The CAA also indicated pressure ulcers triggered due to post CVA and was now on a turring and repositioning schedule every two hours and as needed. She was currently receiving Physical Therapy (PT) and Occupation Therapy (OT) for strengthening and endurance related to the CVA. R73's care plan dated 6/2/1/7, identified she had impaired cognition related to Alzheimer's Disease, but was alert to self, some family and knowledge she was not at home. The care plan further indicated she had severely impaired decision making, wandered the facility with a lost look on her face, used a wheelchair for mobility and	31 OLAI	IL LIVING COMMON	TT OF MOTIA	MORA, M	N 55051			
21810 Continued From page 12 making, which was the same as the 9/22/16, Cognitive CAA. However, now R73 required, "increased help since return from hospital with [stroke]." The following new care areas triggered as a result of changes on her 6/21/17 MDS. R73's Visual Function CAA dated 6/26/17, indicated R73 had a change in vision function and now had right field cut vision related to recent CVA (cerebral vascular accident) or (stroke) and used a wheelchair for mobility and she got caught on other's wheelchair wheels when in congested areas. R73's Communication CAA drategered due to recent CVA with a language deficit resident received speech for expressive and receptive aphasia and staff need to assist the resident in finding the correct words for communication. The communication CAA further indicated R73 gets frustrated when unable to find the correct words. The urinary incontinence CAA identified now R73 was occasionally incontinent of urine and needed assistance with toileting and was on a toileting plan every two hours and as needed. The urinary incontinence CAA further indicated due to altered communication R73 was at greater risk for incontinence. The CAA also indicated pressure ulcers triggered due to post CVA and was now on a turning and repositioning schedule every two hours and as needed. She was currently receiving Physical Therapy (P7) and Occupation Therapy (OT) for strengthening and endurance related to the CVA. R73's care plan dated 6/21/17, identified she had impaired cognition related to Alzheimer's Disease, but was alert to self, some family and knowledge she was not at home. The care plan further indicated she had severely impaired decision making, wandered the facility with a lost look on her face, used a wheelchair for mobility and								
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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00814	B. WING	·	08/3	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	H 7TH STRE	EET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21810	Continued From pa	ge 13	21810			
	constant curing to the In addition, the care incontinent of urine diagnosis of demer stroke) and needed with dressing, bathic care plan indicated mobility related to cright sided weakness extensive assist of independent with be assistance of one with the care of the control of the care plan indicated mobility related to cright sided weakness extensive assist of independent with be assistance of one with the care incontrol of the care in	ime, place and room location. e plan identified R73 was , had impaired ADL's related to ntia, cerebral infarction (CVA, I extensive assist of of one ng and grooming. Further, the R73 was at risk for impaired liagnosis of cerebral infarction, as (hemi paresis) and needed one with transfers, was ed mobility and needed with a rolling walker. 8/29/17, at 6:54 p.m. R73 was				
	seated in a standar hallway. R73 was I her shoulder agains propelling the whee	d wheelchair in the South wing eaning to the right side with at the rear frame of the chair, elchair using both feet. R73 sensical words, and had a				
	9:22 a.m. R73 was Nursing assistant (IR73 with morning on, and proceeded NA-J assisted and mechanical standing standing position fr R73 in the mechan removed her visibly and seated her on when seated on the washcloth to wash perineal area. R73 participate in her bat to be ambulatory are however, R73 sustango and now require	observation on 8/30/17, at lying in bed in her room. NA)-J entered the room to help ares. NA-J put R73's socks to assist R73 to sit up in bed. strapped R73 into a g lift, and assisted her to a om her bed. NA-J wheeled ical lift to the bathroom, a soiled incontinence product the toilet. R73 did not void a toilet. NA-J used a wet R73's face, back, arms and made no attempts to athing. NA-J stated R73 used and transferred on her own, ained a stroke a few months ared a mechanical lift for heelchair for mobility and was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 14	21810			
	unable to ambulate	anymore.				
	member (FM)-A state would be notified of accident, with R73. ago (R73) developed facility attempted to message on her phin condition. The nustroke and wanted not tell her she had FM-A stated she did until several hours facility back, they had staff to send Ritreatment immediate had stroke symptomight away. FM-A stated too long to stoom for treatment.					
	family member (FM contact, responsible a change in condition	ident Face Sheet indicated I)-A was R73's emergency e party and the person to call if on. Further, the sheet is the secondary contact.				
	Review of R73's Pr Sustaining Treatme by R73's certified n 10/14/15, identified or intubated (DNR/I labeled, "Goals of 1 to be implemented breathing," and iden	ovider Order for Life ent (POLST) dated and signed urse practitioner (CNP)-A on R73 had do not resuscitated DNI) on the POLST. A section reatment," included directions if R73, "has pulse and/or is ntified R73 had "Comfort options that could be selected				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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		00814	B. WING		08/3	1/2017
NAME OF	PROVIDER OR SUPPLIER		ORESS, CITY, S	STATE, ZIP CODE	1 55.5	.,
ST CLA	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	'H 7TH STRI N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	in accordance with box to check or not areas, to clarify the areas on the form wareas on the form wareas, to clarify the areas on the form wareas, to clarify the areas on the form wareas, to clarify the areas on the form wareas, to clarify instead," - "If possible, do not example and the sunchecked, identify implemented. Furth option that was chell interventions and The which was described aimed at treatment injury or non-life the further identifying, "The POLST was significated, "Noted [Find before dinner at 16 unsteady gait, RT [In non-reactive, slurre hand/foot strength before dinner at 16 unsteady gait, RT [In non-reactive, slurre hand/foot strength before dinner at 18 blood] 97% on RA [96.7. Family notifier resident sent into the A First Light Health dated 6/10/17, indicated 18:21 and the prima neuro-stroke/CVA. 6/10/17, at 18:50 vi	R73's wishes. There was a check next to each of these ir wishes of comfort care. The vere: , call [blank line to fill in] t transport to ER [emergency d, t admit to the hospital from the se options were left ring R73 wanted these actions per, R73's POLST identified an ecked which identified, "Limit reat Reversible Conditions," and as, "Provide interventions of new or reversible illness / eatening chronic conditions," Transport to ER presumed." gned by R73, however, was de dated 6/10/17, at 18:23 and by R73, however, was see dated 6/10/17, at 18:23 and by R	21810			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00814	B. WING		08/3	31/2017
	PROVIDER OR SUPPLIER	110 NORT	H 7TH STRE	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	condition was ident R73's ED (emerger Hosp-Admision rep identified R73 had a (stroke). The repor old female with a hi meningioma (non-of from the membrane of CVA's, DM (diable (high cholesterol), hadmitted with probather primary deficit with difficulty and will co for secondary preventherapy were ordered was done and completed on 10/08 CSF (cerebral spinshydrocephalus (fluid away). The CT so acute intracranial al chronic small vesse blood) change, state cerebellar meningic lobe infarct (stroke) to Hosp-Admission admitted to the hos A First Light Health Summary dated 6/1 doctor (MD)-A indic A Brief HPI/PE (hist exam) indicated (F with history of deme MD, hyperlipidemia to the ER with incre with speech. Lives	ified at the nursing home. acy department) to ort dated 6/10/17, at 6:49 p.m. a primary diagnosis of CVA t indicated she was a 75 year				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/3	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NOR MORA, M	TH 7TH STRE N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21810	treatment for condict Pt (patient) took nate to arouse at 1630 anoted a change. It once family was co (POLST listed common treatment for potenthat time, too much known normal time activator that is isold dissolves the clot apart of the brain de an option. Pt has shistory and exam dowers/chills), chest breath), cough or tr (unclear how reliable A First Light Health Physician Criteria for last revised 2/11/10 Inclusion Criteria: -Clearly defined timetPA can be given wonset -Patients over 18 -The patient's symmy with acute ischemic deficit A Senior Care Translated 6/15/17, compractitioner (CNP)-long term care visit was acute CVA. The illness) on the repoold female with past dementia, old CVA diabetes mellitus, in	tions that may be reversible. p at 1430 today. Was difficult and once she was awake staff took time to contact family and ntacted pt was brought to ER fort care but family wanted tially reversible condition). By a time had passed from the last is so tPA (tissue plasminogen nemic stroke treatment that and improves blood flow) was not significant dementia making ifficult. Denies any f/c st pain, sob (shortness of rouble going to the bathroom alle pt is.) no other concerns. System Mora, Minnesota or tPA Use In Stroke guidelines of, indicated the following are of onset of symptoms within 3 hours of symptom so toms are clearly consistent to stroke with measurable and her primary diagnosis and her primary diagnosis and her primary diagnosis and her primary diagnosis and her primary significant for with right side weakness, meningioma and hypertension. To and laid down for nap.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/	31/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ST CLAI	RE LIVING COMMUNI	TY OF MORA	TH 7TH STRE IN 55051	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21810	unstable gait, and obrought to ED for ean acute CVA. She Clare on 6/12/17. Sin speech, difficulty confusion. She is choney thickened liquid bound, gait and bal indicated R73 returned following an acute of cognition, speech a made to PT/OT/SL changed to honey-to the A Speech Therapy Assessment dated indicated R73 was receptive aphasia. prior level of command able to underst structured conversa unfamiliar communication in the c	she had increased confusion, difficulty speaking. She was valuation and felt to have had e stabilized and returned to St. She continues to have deficits swallowing and increased on mechanical soft diet with uids. She is wheelchair ance unstable." The report ned to the nursing home CVA, with primary deficits in and swallow and referrals were P. R73 also had a diet hick liquids, mechanical soft.	21810			
	6/13/17, completed her CVA and after t identified: -gait 150 ft. (feet) p independence (ass needed), currently guard assist (conta unsteadiness)transfers she went	Initial Assessment dated by PT-A indicated that prior to he following deficits were rior with modified istive device or extra time walks 100 ft. with contact ct with patient due to from modified independence needing verbal cures				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		71. 501251110.			
	00814	B. WING		08/3	31/2017
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST CLARE LIVING COMMUNI	TY OF MORA 110 NORT MORA, M	TH 7TH STRE N 55051	EET		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
falls The assessment futo ambulate 100 ft front wheeled walk of goal status indice the patient ambulated assistance and from complete functional assistance and from c	n moderate risk to high risk of arther indicated R73's goal was with contact guard assist and er with right neglect. The end eated her goal was not met and tes 100 ft with minimal nt wheeled walker in order to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00814	B. WING		08/3	1/2017
	PROVIDER OR SUPPLIER	110 NORT	H 7TH STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21810	unaware of the ED it was "too late" to t she was not sent in home. On 8/30/17, at 12:2 with MD-A (who wa at First Light Health hospital discharge s did not return the pl During interview 8/3 stated LPN-C was t and was R73's nurs spoke to LPN-C an waited for the family sending her in was (CNP)-A told him to wanted to do first. remember if he concontact. During interview 8/3 stated on 6/10/17, It the symptoms R73 based on past convonly wanted things and wanted (R73) s infection and if it wadidn't want her sent (R73) had a brain to pain. FM-A was no they would not wan having stroke symp FM-A was upset the away, and stated, "the day it happened upset."	discharge summary identifying reat (R73) with tPA because right away by the nursing 0 p.m. a message was left s not her primary physician) System who completed the summary on 6/12/17. MD-A	21810			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00814	B. WING		08/31/2017	
NAME OF			<u> </u>	OTATE 7/ID OODE	08/3	01/2017
	PROVIDER OR SUPPLIER	110 NORT	DRESS, CITY, 8 T H 7TH STRE	STATE, ZIP CODE EET		
ST CLAF	RE LIVING COMMUNI	TY OF MORA MORA, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	facility medical dire primary physician) hospitalization on 6 director stated if a ners and was having should have been stright away and not call. The medical consumment of pneumonia or some they could have wareviewed the emergestated MD-B was the "Reading MD-B not you have to assum had no CVA symptothey decided not treatime had passed. To stroke could be a rewould make sense away." During interview 8/3 stated during an enexpect the facility to practitioner, and facton the family to call sent her in. The DO specific policy statistic protocol. During interview 8/3 stated he was R73 she woke up he no paralysis so he call she did not think the to the ED because	ctor (who was not R73's reviewed R73's POLST and 6/10/17. The facility medical resident has a POLST like ng stroke symptoms she sent to the emergency room wait for family to return the director stated if she had ething that was not so urgent ited. The medical director gency department note and ne emergency room physician. It is and was sleeping at 1430 ethis was the last time [R73] oms. When she got to the ED eat with tPA because too much the medical director stated a reversible condition and it to send her to the ED right of call the physician or nurse mily. If they were unable to recontact, they should call the and then just send the resident of they should not have waited I back and should have just on stated they don't have a ng this but this was their	21810			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00814	B. WING		08/3	31/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNIT	TY OF MORA 110 NOR' MORA, M	TH 7TH STRE IN 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	LPN-C to send her he was unable to re FM-A, but had not rand was unsure if his secondary contact if though so much time heard from FM-A not again about not bein because CNP-A did on 8/31/17, at 1:12 ED and a message not return the call. During interview 8/3 stated she can not 6/10/17, about not be stated she can not 6/10/	ge 22 M-A called back she told in right away. LPN-C stated ecall the events after calling received a call back right away are attempted to call the FM-B. LPN-C stated even he had passed, he had not for did he recall calling CNP-A and gable to reach FM-A, and not seem too concerned. p.m. a call was placed to the was left for MD-B. MD-B did May CNP-A stated even if gain, she would not have not concerned to the don't want to treat (R73's) away. CNP-A stated even if gain, she would not have not concerned to the don't want to treat (R73). May CNP-A stated even if gain, she would not have not concerned to the don't want to treat (R73). May CNP-A stated even if gain, she would not have not concerned to because she was under the don't want to treat (R73). May CNP-A stated even if gain, she would not have not concerned to the don't want to treat (R73). May CNP-A stated even if gain, she would not have not concerned to the don't want to treat (R73). May CNP-A stated even if gain, she would not have not concerned. May CNP-A stated even if gain, she would not have not concerned. May CNP-A stated even if gain, she would not have not concerned. May CNP-A stated even if gain, she would not have not concerned. May CNP-A stated even if gain, she would not have not concerned. May CNP-A stated even if gain, she would not have not concerned. May CNP-A stated even if gain, she would not have not concerned.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00814	B. WING		08/3	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	TH 7TH STRE	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21810	Continued From pa	ige 23	21810			
	During interview 8/3 p.m. NA-C after R7 sad. NA-C stated the dressed and groom assist to tuck in a bestroke, R73 needs daily needs. During interview 8/3 stated the facility can be a message. The was (R73's) second Although R73 had a 6/10/17, with stroke to provide prompt of sending R73 imme R73's POLST, which treatment for reversal failure to respond in R73 from receiving sensitive and must hours to reverse strot receiving this managericant change in the state of the	31/17, at approximately 3:00 '3's stroke she seems more nat prior to the stroke R73 ned herself with occasional plouse. NA-C stated since the total assistance with all her 31/17, at 3:16 p.m. FM-A called her on 6/10/17, and left refacility did not call FM-B who dary emergency contact. a change in condition on resymptoms, the facility failed remergency treatment by not diately to the ED following the outlined R73's wanted sible conditions. The facility's in a timely manner, prevented tPA medication, which is time be administered within 3 roke symptoms. As a result of nedication, R73 had a in her ADL's and was aff, resulting in actual harm to				
	9/15/08, indicated, emergency or where the facility must confirm mediately and not and if known the reinterested family must change in resident' psychosocial status significantly. c) A definition of the confirmation of the facility of the	inge In Condition reviewed "Except in medical n a resident is incompetent, nsult with the resident offity the residents's physician, sident's legal representative or ember when there is: a) A s physical, mental or s. b) A need to alter treatment ecision to transfer or discharge ne facility." The policy further				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	E SURVEY IPLETED	
		00814	B. WING		08/3	31/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNIT	TY OF MORA 110 NORT MORA, MI	'H 7TH STRE N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	"RN or designee wi designated contact this individual, the r be contacted." A facility policy Emerindicated licensed r for residents in an eprocedure would be 911 would be called problem and do not And in a non-life thremergency care, not for ambulance and A facility policy St. (Mora Policy and Proguidelines And Mai Record dated 1/201 or communication tresident's physician required. When a contification have to and method of all contification have to and method of all contification. Make so include any contification. Make so include and does not motification. Make so shift that a message that they need to for a facility policy St. (A facility policy St. (Continuous facility facili	Inge in status of a resident, the II: 1. Notify the first person 2. If unable to locate next designated individual will ergency Care undated nursing staff will provide care emergency situation and the eto stay with the resident while d, give address, nature of the hang up until told to do so. reatening emergency to give otify physician, if needed call notify family. Clare Living Community Of occedure For Documentation ntaining Legally Sound Health 17, indicated under notification that notification to the eto, nurse practitioner or family is discussion with the resident's ding care of the resident, all on (including attempts at the be charted. Include the time formunications. The entry orders received or responses, of such orders if any and the eto means the definition of sure to report to the the next eto was left with the family and llow up with another call.	21810			
	have a completed F	der "Policy: Each resident will POLST form included in their is form will be completed				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		L`´		(X3) DATE COMP	SURVEY LETED	
		A. BUILDING.	A. BUILDING:			
		00814	B. WING		08/3	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST CLAF	RE LIVING COMMUNI	TY OF MORA 110 NORT MORA, MI	TH 7TH STRI N 55051	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21810	based on wishes of representative ager regularly and kept of the nursing staff, phinvolved with the caplan that states the they want to manage This form will addressed to the end of they desire while live. SUGGESTED MET The director of nurser review policies and implementation of F Sustaining Treatment ensure adequate at then audit to ensure TIME PERIOD FOR days.	is the resident and/or appointed ont. The form will be revived current. Purpose: To provide anysicians, family and all others are of the resident, a written resident's wishes about how ge their treatment and care. The session of the resident and care are their wishes not only of life, but also the quality of life and with a chronic illness." THOD OF CORRECTION: Sing (DON) or designee could procedures regarding Physician Orders for Life and appropriate knowledge and	21810			10/30/17
21000	Residents of HC Far Subd. 20. Grieval shall be encourage their stay in a facilit to understand and opatients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a		21000			10/30/17

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AND BLAN OF CORRECTION TO THE THE TOTAL NUMBERS		` '	ULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
		00814	B. WING		08/3	1/2017
			H 7TH STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21880	nursing home ombour Americans Act, sect posted in a conspice Every acute care residential program 253C.01, every nor facility employing my provides outpatient have a written interest a minimum, sets followed; specifies followed; specifies for facility rest or resident to have advocate; requires grievances; and program an impartial decision otherwise resolved residential program 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed to	udsman pursuant to the Older tion 307(a)(12) shall be	21880			
	by: Based on observati review, the facility for residents and famili	ent is not met as evidenced on, interview and document ailed to resolve concerns from ies regarding flies in the e had the potential to affect all facility.		Correction Completed		

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NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA ST CLARE LIVING COMMUNITY OF MORA STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051			00814	B. WING		08/3	1/2017
ST CLARE LIVING COMMUNITY OF MORA MORA, MN 55051	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	, , , ,	.,
OVANDA CHIMMADY CTATEMENT OF DEFICIENCIES IS BROWNERS OF AN OF CORRECTION	ST CLA	RE LIVING COMMUNI	IV OF MORA		ET		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
Resident council meeting minutes dated 7/25/17, indicated residents had a concern related to flies in the facility. An attached grievance form noted the concern; however, no response was indicated. Resident council meeting minutes dated 8/14/17, did not indicate the flies had been addressed with the resident council. During observation of brunch in the main dining room on 8/28/17, at 10:37 a.m. several flies were flying around the dining room. At 10:49 a.m. a fly landed on R3's left hand as she was eating her fruit crisp. R3 swatted the fly off her hand multiple times, as it continuously landed on her hand. R3 stated "They [flies] sure like me." During interview on 8/28/17, at 10:52 a.m. family member (FM)-A stated "Everyone is sick and tired of flies on their food and their cups, they fithe facility) don't do anything about it." FM-A stated he constantly complained about the flies in the facility, almost every day. FA-A further stated that although the facility had completed steps to decrease the flies the previous year, the facility had not addressed the concerns this year. On 8/28/17, at 10:56 a.m. R6 stated the facility did not do anything about the flies. R6 further stated "It [the flies] bothers me when I'm eating," When interviewed on 8/28/17, at 10:58 a.m. nursing assistant (NA)-D stated there had been a few complaints about the flies in the dining room. NA-D further stated she had not received any instruction on what to do about the flies, or how to handle the residents complaints about the flies, or how to handle the residents complaints about the flies, or how to handle the residents complaints about the flies, or how to handle the residents complaints about the flies, or how to handle the residents complaints about the flies, or how to handle the residents complaints about the flies.	21880	Resident council mindicated residents in the facility. An at the concern; howe indicated. Resident dated 8/14/17, did addressed with the During observation room on 8/28/17, a flying around the d landed on R3's left fruit crisp. R3 swat times, as it continus stated "They [flies] During interview or member (FM)-A stated "They [flies] During interview or member (FM)-A stated interview or flies on their foor facility] don't do an constantly complaint facility, almost ever although the facility decrease the flies in had not addressed On 8/28/17, at 10:5 did not do anything stated "it [the flies] When interviewed nursing assistant (If few complaints about the facility of the flies) when interviewed nursing assistant (If few complaints about the flies) and the flies instruction on what handle the resident did not resident did not do anything stated "it [the flies]	neeting minutes dated 7/25/17, a had a concern related to flies stached grievance form noted ver, no response was to council meeting minutes not indicate the flies had been a resident council. In of brunch in the main dining at 10:37 a.m. several flies were ining room. At 10:49 a.m. a fly hand as she was eating her ted the fly off her hand multiple ously landed on her hand. R3 sure like me." In 8/28/17, at 10:52 a.m. family ated "Everyone is sick and tired d and their cups, they [the ything about it." FM-A stated he ned about the flies in the ry day. FA-A further stated that y had completed steps to the previous year, the facility the concerns this year. In 8/28/17, at 10:58 a.m. In 8/29/17, at 10:58 a.m.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00814	B. WING		08/	31/2017
	PROVIDER OR SUPPLIER	TY OF MORA 110 NO	ADDRESS, CITY, S ORTH 7TH STRE , MN 55051			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21880	On 8/31/17, a 1:12 manager (CDM) sta problem in the dinir two ago and stated of the problem. The voiced complaints a When interviewed wellness director (Vinentioned flies at to July. WD stated followeting, WD broughte administrator. We resident council me complaints regarding not ask the resident concerns and the response to the prefilies. During interview on administrator stated through the french the doors were operactivities in the counstated he was aware members complaints. Facility placed fly lig moved the facility of the reduce the flies. The had not addressed about the flies this sucorrect the issue. The had not contacted contractor this year.	p.m. the certified dietary ated the flies had become a ng room again about a week the administrator was aware CDM further stated FM-A h	e add in lie d d t d e add t s o			

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PRINTED: 10/12/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00814 08/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET ST CLARE LIVING COMMUNITY OF MORA MORA, MN 55051 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21880 Continued From page 29 21880 addressed his fly concern in the facility. FM-A further stated it was pointless to complain anymore as nothing ever gets done about the flies The undated facility policy, Concerns and Grievances indicated the term "voice concerns" is not limited to a formal, written grievance process, but may include a resident's verbalized concerns to staff. The staff person responsible investigates, resolves the issue, and responds back to the customer within five business days. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures regarding grievances to ensure feedback is communicated, then inservice staff regarding the process and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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