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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NVD0
Facility ID: 00814

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

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

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

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

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

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

6. DATE OF SURVEY **11/01/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

- ___ 2. Technical Personnel
- ___ 3. 24 Hour RN
- ___ 4. 7-Day RN (Rural SNF)
- ___ 5. Life Safety Code
- ___ 6. Scope of Services Limit
- ___ 7. Medical Director
- ___ 8. Patient Room Size
- ___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jen Bahr, HFE NE II 11/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 11/30/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY

_X_ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
- 01-Merger, Closure
- 02-Dissatisfaction W/ Reimbursement
- 03-Risk of Involuntary Termination
- 04-Other Reason for Withdrawal

INVOLUNTARY
- 05-Fail to Meet Health/Safety
- 06-Fail to Meet Agreement

OTHER
- 07-Provider Status Change
- 00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 12/07/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/16/2017** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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.

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NVD0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00814

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **08/31/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 10/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/13/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 10/16/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda 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) AND 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING ______ B. WING ______	08/31/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/28/17 to 8/31/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). St. Clare Living Community was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 155 SS=G	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 155		10/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	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. 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 physician orders and the resident's advance	F 155		

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F 155	Continued From page 2 directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide emergency services according to POLST (provider orders for life sustaining treatment) for 1 of 1 resident (R73) who showed stoke symptoms, and was not immediately sent to the emergency department (ED) as directed by her POLST. This resulted in actual harm for R73 who had a decline in her condition, as a result of the facility not following her POLST. Findings include: R73's quarterly Minimum Data Set (MDS) dated 6/1/17, indicated she was severely cognitively impaired, needed staff supervision with assistance of one for activities of daily living (ADLs), she needed set up assistance with eating and physical assistance of one for bathing. There were no other limitations of R73's ADL's during this assessment period. R73's significant change MDS dated 6/21/17, identified the following changes in her activity of daily living (ADL) status: She now needed limited assistance of one with bed mobility, transfers, dressing and toileting. In addition the MDS indicated she was totally dependent upon staff for toileting, ambulated only once or twice and needed staff supervision and assistance of one with eating. R73 remained severely cognitively impaired which was the same on 6/1/17. R73's most recent Cognitive CAA dated 6/21/17, identified R73 had dementia with severely impaired decision making, which was the same	F 155	F155 Right to Refuse; Formulate Advance Directives St. Clare Living Community of Mora has a very strong program and history of honoring our resident care wishes including any Advance Directives that they may wish to develop. Our facility recognizes and encourages residents and families to let their wishes be known to care providers using the POLST protocols. During the survey the surveyors reviewed R73 s POLST, MDS, and Care Plan as it related to an incident pertaining to a hospitalization on 6/10/17. Review of R73 s POLST date and sign by the CNP on 10/14/15, identified R73 was Do Not Resuscitate or Intubate (DNR/DNI). The Section labeled Goal of Treatment included directions to be implemented if R73 has pule and/or is breathing, which indicated R73 being on Comfort Care with several options that could be selected in accordance with R73 s wishes. There is a box to check or not check next to each area to clarify resident s wishes. The areas that can be checked are: Avoid call 911, call ________________(blank line to be filled in) instead If possible, do not transport to ER If possible, do not admit to the hospital from the ER All of these options were left unchecked R73 POLST was reviewed and revised with the resident, family, the CNP and the	

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F 155	Continued From page 3 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 on the 6/21/17 MDS for a CAA assessment, which was not completed on the 9/22/16 CAA. R73 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. 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 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 (PT) and Occupation Therapy (OT) for strengthening and endurance related to the CVA. During observation 8/29/17, at 6:54 p.m. R73 was seated in standard wheelchair in the South wing hallway. R73 was leaning to the right side with her shoulder against the rear frame of the chair, and was propelling the wheelchair using both feet. R73 was mumbling non nonsensical words, and had a furrowed brow facial expression.	F 155	Director of Nursing on 9/27/17 and filed in resident chart. The facility has reviewed its Advance Directive policies and updated the POLST form to be more comprehensive and identify resident wishes clearly directing care providers regarding resident wishes. Education of the licensed staff on the revised Advance Directive policies and procedure will be conducted on Tuesday, 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 POLST was completed on 9/29/17 and updated as appropriate. Then an audit of 25% of current residents POLST will be completed weekly for four weeks; then 25% will be completed monthly for the next four months, then quarterly thereafter. Ongoing review of resident Advance Directives will also be conducted upon admission; upon hospital return; and 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 for compliance. The results of the audit of current residents POLST will be reported to the QA committee as will the revised Advance Directive policies at their October meeting. Ongoing review of the audits will become part of their regular agenda for future QA Meetings. Further system revisions and staff education will be provided if indicated by audits and/or	

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During subsequent observation on 8/30/17, at 9:22 a.m. R73 was lying in bed in her room. Nursing assistant (NA)-J entered the room to help R73 with morning cares. NA-J put R73's socks on, and proceeded to assist R73 to sit up in bed. NA-J assisted and strapped R73 into a mechanical standing lift, and assisted to a standing position from her bed. NA-J wheeled R73 in the mechanical lift to the bathroom, removed her visibly soiled incontinence product and seated her on the toilet. R73 did not void when seated on the toilet. NA-J used a wet washcloth to wash R73's face, back, arms and perineal area. R73 did not participate in the bathing. NA-J stated R73 used to be ambulatory and transferred on her own, however, R73 sustained a stroke a few months ago and now required a mechanical lift for transfers, used a wheelchair for mobility and was unable to ambulate.

R73's undated Resident Face Sheet indicated family member (FM)-A was R73's emergency contact, responsible party and the person to call if a change in condition. Further, the sheet indicated FM-B was the secondary contact.

During interview on 8/29/17, at 1:41 p.m. family member FM-A stated she was the person who would be notified of a change in condition, or accident, with R73. FM-A stated a few months ago (R73) developed stroke symptoms and the facility attempted to call her, however, just left a message on her phone about her sudden change in condition and they thought she had a stroke and wanted me to call back they didn't say she wasn't sent to the hospital. FM-A stated she did not receive the message until several hours later.

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When she called the facility back, they had not sent (R73) to the hospital for these symptoms. FM-A stated she told staff to send R73 to the emergency room for treatment immediately and thought if someone had stroke symptoms should have gone in right away. FM-A stated she was unaware why the facility did not send her immediately to the hospital, adding she was upset the facility waited too long to send (R73) to the emergency room for treatment.

During interview 8/30/17, at 8:02 a.m. registered nurse (RN)-B stated she was the clinical manager and MDS coordinator. RN-B stated that R73's FM-A wanted to make sure if anything happened to (R73) that was reversible she wanted her to be hospitalized FM-A has told us this multiple times.

During interview 8/30/17, at 11:41 a.m. the director of nursing (DON) stated when R73 woke up on 6/10/17, and showed symptoms of a stroke she should have been sent her to emergency department right away. It was my understanding that FM-A would want her sent in right away and staff should not have waited for FM-A to call back. The DON stated (R73) she was walking before her stroke, and feeding herself. Now she needs a wheelchair and supervision with eating. The DON further stated she was not aware the licensed practical nurse (LPN)-C waited so long for FM-A to call the facility back, and was unaware of the ED discharge summary identifying it was "too late" to treat (R73) with tPA because she was not sent in right away by the nursing home.

On 8/30/17, at 12:20 p.m. a message was left with MD-A (who was not her primary physician) at First Light Health System who completed the

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hospital discharge summary on 6/12/17. MD-A did not return the phone call.

During interview 8/31/17, at 9:00 a.m. the DON stated LPN-C was the nurse working on 6/10/17 and was R73's nurse. The DON stated she spoke to LPN-C and he stated the reason why he waited for the family to return the call instead of sending her in was because the nurse practitioner (CNP)-A told him to wait and see what the family wanted to do first. LPN-C stated he could not remember is he contacted the secondary family contact.

During interview 8/31/17, at 9:12 a.m. CNP-A stated on 6/10/17, LPN-C called her and told her the symptoms R73 was having. CNP-A stated based on past conversation with the FM-A they only wanted things treated that were reversible and wanted (R73) sent in for things like an infection and if it was a chronic condition she didn't want her sent in. CNP-A further stated (R73) had a brain tumor and chronic abdominal pain. FM-A wasn't treating that so she assumed they would not want her sent in when she was having stroke symptoms. The CNP-A stated FM-A was upset that she wasn't sent in right away, and stated "I knew she was upset since the day it happened, I am well aware she is upset.".

During interview 8/31/17, at 10:46 a.m. with the facility medical director who was not R73's primary physician reviewed R73's POLST and hospitalization on 6/10/17. The facility medical director stated if a resident has a POLST like hers and was having stroke symptoms she should have been sent to the emergency room right away and not wait for family to return the call. The medical director stated if she had

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pneumonia or something that was not so urgent they could have waited. The medical director reviewed the emergency department note and stated MD-B was the emergency room physician. "Reading MD-B note and was sleeping at 1430 you have to assume this was the last time (R73) had no CVA symptoms. When she got to the ED they decided not treat with tPA because too much time had passed. The medical director stated a stroke could be a reversible condition and it would make sense to send her to the ED right away".

During interview 8/31/17, at 11:19 a.m. the DON stated during an emergency situation she would expect the facility to call the physician or nurse practitioner , and family. If they were unable to contact the primary contact, then they should call the secondary contact and then just send the resident in. The DON stated they should not have waited for the family to call back and should have just sent her in. The DON stated they don't have a specific policy stating that but it is their protocol.

During interview 8/31/17, at 12:57 p.m. LPN-C stated he was R73's nurse on 6/10/17, and when she woke up he noted a facial droop and paralysis so he called the CNP-A, who told him she didn't think the family would want her to go to the ED because of her diagnosis or something. LPN-C stated he called (FM)-A and left a message. When FM-A called back she told me to send her in right away. LPN-C stated he was unable to recall the events after calling FM-A, but had not received a call back right away and was unsure if he attempted to call the secondary contact FM-B. LPN-C stated even though so much time had passed, he had not heard from FM-A nor did he recall calling CNP-A again about

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F 155	Continued From page 8 not being able to reach FM-A, because CNP-A did not seem too concerned. On 8/31/17, at 1:12 p.m. a call was placed to the ED and a message was left for MD-B. MD-B did not return the call. During interview 8/31/17 at 1:33 p.m. CNP-A stated she can not recall if LPN-C called her on 6/10/17 about not being able to reach (R73's) FM-A or FM-B right away. CNP-A stated even if LPN-C called me again, she would not have not changed her decision because she was under the impression FM-A did not want to treat (R73). During interview 8/31/17, at 3:16 p.m. FM-A stated the facility called her on 6/10/17 and left her a message. The facility did not call FM-B who was (R72's) secondary emergency contact. Review of R73's Provider Order for Life Sustaining Treatment (POLST) dated and signed by R73's certified nurse practitioner (CNP)-A on 10/14/15, identified R73 was do not resuscitated or intubated (DNR/DNI). A section labeled, "Goals of Treatment," included directions to be implemented if R73, "has pulse and/or is breathing," which indicated R73 being on, "Comfort Care," with several options that could be selected in accordance with R73's wishes. There was a box to check or not check next to each of these areas, to clarify their wishes. The areas on the form were: - "Avoid calling 911, call [blank line to fill in] instead," - "If possible, do not transport to ER [emergency department] ...," and, - "If possible, do not admit to the hospital from the ER ..."	F 155		

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However, all of these options were left unchecked, identifying R73 wanted these actions completed. Further, R73's POLST identified a checked option for, "Limit Interventions and Treat Reversible Conditions," which described, "Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions," further listing, "Transport to ER presumed." The POLST was signed by R73, however was undated.

R73's progress note dated 6/10/17, at 18:23 indicated, "Noted [R73] was difficult to rouse before dinner at 1615. Noted resident with unsteady gait, RT [right] facial droop, RT pupil non-reactive, slurred/slow speech, and bilateral hand/foot strength WNL [with in normal limits]. BP [blood pressure] 149/52, P [pulse] 73, RR [respiration rate] 18, Sp02 [oxygen saturation in blood] 97% on RA [room air] and T [temperature] 96.7. Family notified writer at 1815 that they want resident sent into the hospital to get checked out."

A First Light Health System Ambulance Report dated 6/10/17, indicated dispatch was called at 18:21 and the primary impression was neuro-stroke/cva. R73 arrived at the hospital on 6/10/17, at 18:50 via ambulance, 2 hours and 35 minutes after R73's significant change in condition was identified at the nursing home.

R73's ED (emergency department) to Hosp-Admision report dated 6/10/17, at 6:49 p.m. identified R73 had a primary diagnosis of CVA (stroke). The report indicated she was a 75 year old female with a history of dementia, meningioma (non-cancer brain tumor that arises from the membranes to the spinal cord), history of CVA's, DM (diabetes mellitus), hyperlipidemia

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(high cholesterol), HTN (hypertension) and was admitted with probable CVA. The report indicated her primary deficit was confusion with speech difficulty and will continue Plavix (blood thinner) for secondary prevention. PT/OT and speech therapy were ordered at the hospital. In addition the report indicated a CT (cat scan) of the head was done and compared to a previous CT completed on 10/09/15, the findings indicated CSF (cerebral spinal fluid) spaces with no hydrocephalus (fluid in the brain), atrophy (waste away). The CT scan impression indicated no acute intracranial abnormality, stable atrophy and chronic small vessel ischemic (restriction of blood) change, stable anterior lateral left cerebellar (area of the brain that controls coordination and balance) meningioma and chronic right frontal lobe infarct (stroke). A Progress Note on the ED to Hosp-Admission report indicated on 6/11/17, that R73 was admitted on 6/10/17, with a CVA.

A First Light Health System Hospital Discharge Summary dated 6/12/17, completed by medical doctor (MD)-A indicted she had a acute CVA. A Brief HPI/PE (history of present illness/physical exam) indicated she was a 75 year old female with history of dementia, meningioma, prior CVA, MD, hyperlipidemia and hypertension (which blood pressure) presented to the ER with increased confusion and difficulty with speech. Lives in SNF (skilled nursing facility) due to dementia. IS DNR/DNI but family wants treatment for conditions that may be reversible. Pt (patient) took nap at 1430 today. Was difficult to arouse at 1630 and once she was awake staff noted a change. It took time to contact family and once family was contacted pt was brought to ER (POLST listed comfort care but family wanted

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treatment for potentially reversible condition). By that time, too much time had passed from the last known normal time so tPA (tissue plasminogen activator that is ischemic stroke treatment that dissolves the clot and improves blood flow to the part of the brain deprived of blood flow) was not an option. Pt has significant dementia making history and exam difficult. Denies any f/c (fevers/chills), chest pain, sob (shortness of breath), cough or trouble going to the bathroom (unclear how reliable pt is.) no other concerns."

A First Light Health System Mora, Minnesota Physician Criteria for tPA Use In Stroke guidelines last revised 2/11/10, indicated the following Inclusion Criteria:
-Clearly defined time of onset of symptoms
-tPA can be given within 3 hours of symptom onset
-Patients over 18
-The patient's symptoms are clearly consistent with acute ischemic stroke with measurable deficit

A Senior Care Transitions Long Term Care Visit dated 6/15/17, completed by CNP-A indicated she was seen for a long term care visit and her primary diagnosis was acute CVA. The HPI (history of present illness) on the report indicated she was a "75 year old female with past medical history significant for dementia, old CVA with right side weakness, diabetes mellitus, meningioma and hypertension. She felt ill on 6/10/17 and laid down for nap. When she awoke, she had increased confusion, unstable gait, and difficulty speaking. She was brought to ED for evaluation and felt to have had an acute CVA. She stabilized and returned to St. Clare on 6/12/17. She continues to have deficits in speech, difficulty

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	245291	A. BUILDING ______ B. WING ______	08/31/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 12 swallowing and increased confusion. She is on mechanical soft diet with honey thickened liquids. She is wheelchair bound, gait and balance unstable." The report indicated R73 returned to the nursing home following an acute CVA, primary deficits in cognition, speech and swallow and referrals were made to PT/OT/SLP. R73 had her diet changed to honey-thick liquids, mechanical soft. Although R73 had a change in condition on 6/10/17, with stroke symptoms. The facility failed to provide prompt emergency treatment by not sending R73 immediately to the ED following R73's POLST, which outlined R73 wanted treatment for reversible conditions. The facility's failure to respond in a timely manner, prevented R73 from receiving tPA medication, which is time sensitive and must be administered within 3 hours to reverse stroke symptoms. As a result of not receiving this medication, R73 had a significant change in her ADL's and was dependent upon staff, resulting in actual harm to R73 by not following R73 POLST. A facility policy St. Clare Living Community dated 3/8/11, indicated under "Policy: Each resident will have a completed POLST form included in their medical record. This form will be completed based on wishes of the resident and/or appointed representative agent. The form will be reviewed regularly and kept current. Purpose: To provide the nursing staff, physicians, family and all others involved with the care of the resident, a written plan that states the resident's wishes about how they want to manage their treatment and care. This form will address their wishes not only related to the end of life, but also the quality of life they desire while living with a chronic illness."	F 155		

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F 166 SS=C	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		10/30/17

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F 166	Continued From page 14 conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 166		

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F 166	Continued From page 15 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to resolve concerns from residents and families regarding flies in the facility. This practice had the potential to affect all 56 residents in the facility. Findings include: 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 [the facility] don't do anything about it." FM-A stated he constantly complained about the flies in the	F 166	F166 483.10 (j)(2)-(4) Right to Prompt Efforts To Prompt Efforts To Resolve Grievances St. Clare Living Community of Mora has an established grievance policy and procedure to ensure the prompt resolutions of all grievances. This procedure includes identifying the issue, interviewing the person who filed the complaint to ensure clarification of the issue, and assigning it to a staff member to resolve and/or follow up on the issue. In the summer of 2016 the issue of the flies was address with the installation of pest control light in the main dining room and at the delivery entrance. This was communicated to the residents, family and staff at that time. It appeared to resolve the issue for the main dining room. In the spring of 2017 we purchased two additional Pest Control lights for South Dining Room and for West Dining. This summer we have been encouraging resident to use our courtyard by having scheduled events. Their access to that courtyard is through the French doors in the main dining room. The administrator has met with (FM)-A on 8/31/17 to address the issue of the flies.	

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F 166	Continued From page 16 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. During interview on 8/29/17, at 12:28 p.m. R82 stated there were numerous flies hanging around and noticed them mainly in the dining room. On 8/31/17, a 1:12 p.m. the certified dietary manager (CDM) stated the flies had become a problem in the dining room again about a week or two ago and stated the administrator was aware of the problem. The CDM further stated FM-A had voiced complaints about the flies. When interviewed on 8/31/17, at 1:13 p.m. the wellness director (WD) stated the residents mentioned flies at the resident council meeting in July. WD stated following the resident council meeting, WD brought the resident concern to the the administrator. WD stated at the August resident council meeting residents had no complaints regarding the flies. However, WD did not ask the residents specifically about fly concerns and the residents were not given a response to the previous months concern about flies.	F 166	He will be meet again with (FM)-A on 9/29/17 to follow up with him and to discuss the additional steps that we are taking to address the fly issue. The Grievance Policy and Procedures have been reviewed and revised. Education on the revised policy will be conducted at the All Staff Meeting on October 5, 2017. The updated policy will be reviewed with the Resident Council on October 9, 2017. Communication on the revised policy and procedure and the revised Customer Concern form will be sent to all current resident families no later than October 20, 2017. Also the policy and Customer Concern form will be included in the admission packet for all new admissions. Customer Concerns will be reviewed at the facility 's daily management meeting including items identified at the monthly resident council meeting. All open concerns and closed concerns will be reviewed at the monthly management meeting to determine additional interventions and/or compliance. A summary report of the concerns will be presented at the Quarterly QA for further review and input on trends. The Director of Social Service will be responsible for monitoring for on-going compliance. Date Corrected: 10/30/17	

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F 166	Continued From page 17 During interview on 8/31/17, at 1:22 p.m. the administrator stated the flies were coming in through the french doors in the dining room, as the doors were open, to allow residents to attend activities in the courtyard. The administrator stated he was aware of the resident council members complaint about the flies, as well as FM-A's complaints. The administrator stated the facility placed fly lights through out the facility and moved the facility dumpster last year in an effort to reduce the flies. The administrator stated he had not addressed resident and family concerns about the flies this year as he wasn't sure how to correct the issue. The administrator further stated he had not contacted the facility's pest control contractor this year regarding the flies. On 8/31/17, at 3:48 p.m. FM-A stated the administrator had never verbally or in writing addressed his fly concern in the faciilty. 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.	F 166		
F 226 SS=C	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement	F 226		10/15/17

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F 226	Continued From page 18 written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow their policy on completing background checks before hiring for 1 of 5 nursing assistants (NA-A) which were newly hired in the last 6 months. This had the potential to affect all residents being care for in the facility. Findings include:	F 226	F226 Development/Implement Abuse/Neglect Policy It is the policy of St. Clare Living Community to prevent and protect all residents from abuse, neglect, financial exploitation, and misappropriation of property. It is also the policy of St. Clare Living Community to not employ	

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F 226	Continued From page 19 The facility policy Abuse Prevention Plan for Nursing, dated as revised 11/16, identified in Screening of All Potential Employees that "Criminal background checks will be conducted." Review of nursing assistant (NA)-A's human resource file, it was noted NA-A was originally hired on 9/30/15, with a background study dated 10/5/15 received, indicating NA-A was able to provide direct care. In further review of NA-A's human resource file, it was noted that on 4/12/17, NA-A voluntary termination her employment from the facility. However, NA-A was rehired on 5/6/17, (35 days later), with no evidence that an updated background study had been submitted to the state agency for review. During interview on 8/30/17 at 10:40 a.m., the human resource director (HRD) identified the facility did not submit a criminal background study for NA-A's rehire on 5/6/17. The HRD further stated they thought the facility had "a 30 day grace period" after a voluntary termination, to rehire without having to resubmit a criminal background check.	F 226	individuals who have been found guilty of abuse, neglect, mistreatment, financial exploitation, or misappropriation of property. Employee NA-A has been taken off the schedule. Employee will have criminal background study completed prior to her return to St. Clare Living Community. All potential employees will 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 state licensing authorities or Nursing Assistant Registry. b.) The facility will prohibit employment of individuals with disciplinary action in effect against their professional license by a state licensure body as a result of finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of property. c.) Criminal background checks will be conducted. All new employee files will be audited prior to the first day of General Orientation for current criminal background study. In addition, all current employee files will be audited to ensure compliance with background studies by October 15, 2017. The issues identified in this FTag was discussed with all staff at their all staff meeting on October 5, 2017. The Human Resources Director or Designee will be responsible for compliance. Audit results will be reported to the QA/QI	

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F 226	Continued From page 20	F 226	Committee at their October 2017 Meeting for further review and recommendation. Upon this review, system revisions will be implemented if indicated via a prescribed corrective action plan. Date of Correction: 10/15/17	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 279		10/30/17

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F 279	Continued From page 21 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 1 residents (R53), reviewed for refusal of care. R53's electronic record's Face Sheet (undated), indicated resident had the diagnoses of lymphedema, severe morbid obesity, abnormal weight gain, and congestive heart failure. A	F 279	F279 Develop Comprehensive Care Plans It is the policy of St. Clare Living Community of Mora to use the results of assessment to develop, review, and revise the resident comprehensive plan of care. Resident R53 does have a comprehensive care plan which was reviewed and revised on 8/2/17 at her	

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F 279	Continued From page 22 quarterly Minimum Data Set (MDS), dated 7/20/2017, indicated R53 was cognitively intact, was independent with minimal supervision of 1 staff to complete activities of daily living, with no behavior issues. R53's current Physician Order Report (print date 8/31/17), identified the following diet: "CSC (consistent carbohydrate) 2 gram sodium restriction 1800 ML (milliliter) FR (fluid restriction) NO sweeten beverages in room *MAX of 500 ML at bedside at one time" diet. During R53's interview on 08/28/2017 at 1:18 p.m., R53 stated "We have a lady on nights and she dislikes me. I asked for ice one night and she told me I couldn't have any and that I have already had ice for the night." R53 further stated the same staff person came in to give her 4:30 am medications and was mad. She did not have water for her to take with the medication. R53 stated the nurse was "very rude to me" and "we argue a number of times." R53 stated that she had reported the nurse to the director or nursing (DON) and nothing has changed. During observation on 8/29/17 at 6:20 p.m., R53 was leaving the utility hall on the facility's north wing (where a ice machine is located) pedaling her wheel chair with her feet, holding a large mauve colored thermal mugs full of ice chips, returning to her room. In further interview with R53, 8/30/17 at 12:11 p.m., R53 stated she signed a paper that relieved that facility of responsibility should "I die for not following the fluid restriction." R53 denied being able to self access the ice machines, relying on staff to provide her ice. During this interview, R53	F 279	quarterly care conference. During the survey R53 displayed behavioral issues pertaining to her fluid restrictions. This included disruptive interaction with direct care giver in an attempt to get fluid out side of her current restrictions. The comprehensive care plan did include identification of behavior issues with interventions. However, it did not include interventions pertaining to manipulative behaviors. R53 s comprehensive care plan was reviewed and revised by the IDT team to include interventions for manipulative behaviors on 9/29/17. Education on updating and developing comprehensive care plans with intervention was conducted on 10/3/17. Audit of comprehensive care plans for residents who have identified behaviors issues will be conducted by 9/29/17 to ensure that the care plan is complete, including effective interventions. Further identification of behaviors will be discussed with the IDT team on a daily basis (M-F) at their morning meeting; any necessary interventions will result in the updating of the care plan, and behavior monitoring sheets. Results of these audits will be reported to the QA/QI committee at their quarterly meetings. Date of Correction: 10/30/17	

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F 279	Continued From page 23	F 279		

was placing ice cubes into an empty beverage bottles and placing them on the floor next to her recliner chair, leaving her ice mug empty.

Review of R53's medical record progress notes, the following was documented by facility staff:

"8/13/17 - Resident requesting more fluids at 0200 in the middle of the night. Resident currently on fluid restrictions and able to receive 360cc's [cubic centimeters] during the night shift. NAR [nursing assistant] gave resident 360cc's of H2O [water] between 2300-2400 per resident request. At 0430 resident requests that writer bring her PRN oxycodone for pain to her back area. Writer administered that along with other early a.m. scheduled medications. When writer arrived with pills resident immediately stated in a snarky tone," You better have something to drink for me to take those since your the [drinking] police and won't allow me to have anything." Writer explained orders and restrictions stating she was just following Dr. orders per MAR. Resident became more upset raising her voice, yelling at writer calling writer [profanity used], and a not good worker with an attitude. NAR was standing outside of room listening to whole conversation d/t [due to] her hearing resident yell at writer all the way in the day room. Writer attempted to calm resident down which did not work resident continued to yell at writer, put her down and be verbally abusive. Writer gave resident about 50cc's of H2O to take medication with. Resident took pills and threw med cup towards writer. BS obtained with results in matrix."

"8/27/17 - blood glucose prior to brunch: 392. insulin administered as ordered. to DR for both meals. ref wellness activity. filled ice pitcher X 2

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F 279	Continued From page 24 (times 2) this shift per self. writer recommended to resident to inform staff of this so accurate FR (fluid restriction) may be followed. resident stated she keeps tract of her fluids." Review of R53's comprehensive care plan, last updated 8/02/17, did not identify any behavioral issues, other than briefly in the nutritional section which indicated "consumes food and fluid outside recommended diet and fluid restrictions. Obtains and consumes fluid/food independently." The approaches for the nutrition care plan, listed the prescribed diet with the handwritten addition (dated 7/10/17) "provide and served diet as ordered - fluid restriction as ordered." There was no mention of R53's behavior and verbal altercations with staff regarding these care related issues. During an interview on 8/30/17 at 7:29 a.m. licensed practical nurse (LPN)-B, who worked evening, stated that "R53 use to ask for water in the evenings, but has not recently." LPN-B stated (R53) is still mad that LPN-B was encouraging enforcement of R53's physician ordered fluid restriction, while she would ask for both ice and water every evening. Review of R53's Social Service Assessment (from original admission, dated 5/9/16), indicated in the section of BEHAVIORS - "No Behaviors. Social Service updated this assessment for R53's readmission (on 2/8/17) on 2/16/17 documenting within the narrative note "Is non-complaint with fluid restrictions." During interview on 8/30/17 12:33 p.m., social worker (SW) stated the interdisciplinary team (IDT) has spoken with R53 in regards her fluid	F 279		

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F 279	Continued From page 25 restriction, however, "R53 will do only what she believes is correct." During an interview on 8/30/17 at 1:55 p.m., the nurse practitioner (NP)-A stated (R53) has had multiple education settings, with nephrology, cardiology and facility staff, and continues to not follow these restrictions. On 08/31/2017 at 8:36 a.m. the director of nursing (DON) stated R53 has displayed behaviors of refusing physician ordered health interventions, and had been education by both facility and outside medical staff. DON stated that resident has the right to refuse treatment, however, the facility needs to care plan and educate staff on how to respond to R53's behavior of non-compliance.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete grooming as directed by the care plan for 1 of 3 residents (R73) reviewed for activities of daily living (ADLs). Findings include:	F 282	F282 Services by Qualified Persons/per Care Plan It is the policy of St. Clare Living Community to provide care and services by qualified persons in accordance with each resident s written plan of care. For	10/30/17

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F 282 Continued From page 26

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.

During observation on 8/28/17, at 1:20 p.m. R73 was observed to be sitting in her wheelchair in the day room with multiple visible facial hair on her chin down to the middle of her neck approximately 3/8 inches in length.

During observation 8/29/17, at 12:26 p.m. R73 was sitting in her wheelchair in the south hall by the doorway with visible facial hair on her face and chin.

During interview 8/29/17, at 6:45 p.m. trained medical assistant (TMA)-A stated R73 is pretty good with receiving cares she might say no to toileting but she will allow us to do grooming. In subsequent interview at 7:06 p.m. TMA-A stated looking at R73's facial hairs "Oh, there is something that could be done with that she should have been shaved on . That is done on her bath day."

Review of the Bath Book indicated that she received her bath on Friday 8/25/17.

During observation and interview 8/30/17, at 9:22

F 282

the resident R73 the care plan and resident assignment sheet were reviewed and revised. The issues that were identified in the survey were addressed with the direct care staff responsible for R73 on 8/30/17. Education for direct care staff pertaining to oral care and personal hygiene (including facial hair) was conducted at the NA/R meeting held on 10/12/17. This topic was also discussed at the licensed staff meeting held on 10/3/17.
Like residents who are dependent upon personal care will be monitored through oral care and facial hair audits which will be conducted three (3) time per week for 30 days; then weekly for 30 days; monthly for three months; and then randomly thereafter. Results of these audits will be reported to the QA/QI at their quarterly meetings. Further system revision and staff education will be provided if indicated by audits and/or recommended by the QA/QI committee.
The director of nursing or designee is responsible for monitoring on-going compliance.

Date Corrected: 10/30/17

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F 282	Continued From page 27 a.m. R73 was lying in bed with visible facial hair from her chin to the middle of her neck. Nursing assistant (NA)-J entered the room. NA-J put R73's socks on proceeded to sit R73 up in bed she brought a standing lift to her bed and attached the straps under her arms and proceeded to lift her up in a standing position with the lift. NA-J then wheeled the lift to the bathroom removed her incontinent pad and lowered her onto the toilet. NA-J then proceeded to wash her face, back arms and legs and peri area and dressed her. NA-J then lifted R73 back up with the standing lift and lowered into her wheelchair. NA-J then stated all we have left to do now is comb your hair. NA-J combed R73's hair and then wheeled her into the hallway. NA-J did not provide oral care or shave her facial hair. During interview 8/30/17, at 11:39 a.m. the director of nursing (DON) stated the staff should be removing facial hair as they are doing cares and it could also be done during there bath or if they notice it. The DON further indicated oral care should be done with a.m. and p.m. cares. The DON stated a.m. cares is when they get the residents up for the morning and that she should have been shaved and received oral care. The DON stated she will let the staff know to shave her and do oral cares. During interview 8/30/17, at 1:59 p.m. NA-J stated the DON inforrmed her that R73 did not receive oral care and was not shaved with a.m. cares when I got her dressed in the morning. I completed these cares after her lunch today when I was informed by the DON. NA-J further stated she completes these cares after lunch.	F 282		
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES	F 309		10/30/17

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F 309 SS=G	Continued From page 28 FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 309	F309 Provide care/services for highest	

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review, the facility failed to provide timely emergency medical services for 1 of 1 residents (R73) who had stroke symptoms and subsequent stroke which caused physical impairment that limited R73's ability to complete activities of daily living (ADL's), that resulted in actual harm.

Findings include:

R73's quarterly Minimum Data Set (MDS) dated 6/1/17, indicated she was severely cognitively impaired, needed staff supervision with assistance of one for activities of daily living (ADLs), she needed set up assistance with eating and physical assistance of one for bathing. There were no other limitations of R73's ADL's during this assessment period.

R73's significant change MDS dated 6/21/17, identified the following changes in her activity of daily living (ADL) status: She now needed limited assistance of one with bed mobility, transfers, dressing and toileting. In addition, the MDS indicated she was totally dependent upon staff for toileting, ambulated only once or twice and needed staff supervision and assistance of one with eating. R73 remained severely cognitively impaired which was the same on 6/1/17.

R73's most recent Cognitive Care Area Assessment (CAA) dated 6/21/17, identified R73 had dementia with severely impaired decision 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

F 309

well being

It is the policy of St. Clare Living Community of Mora to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment and care plan.
The care plan and the Advance Directive (POLST) was reviewed and revised on 9/27/17. The facility has reviewed its Advance Directive Policies and updated the POLST form to be more comprehensive and clearly identify resident wishes directing care providers regarding resident wished. The policy for Emergency Care was also reviewed and revised by IDT 9/29/17.
Education of the licensed staff on the revised Emergency Care procedures and situational events was conducted on 10/03/17. General education on Emergency Care and Advance Directives for all staff was conducted on Thursday 10/05/17. More specific education on Emergency Care and Advance Directives will be conducted on 10/12/17. Random Audits of staff on Emergency Care/Situational Events and Advance Directives will be conducted at the following rate: 4 staff audits per week for four weeks; 5 staff audits per month for the next three month; then 3 staff audits quarterly thereafter.
Emergency Care Events will be reviewed at the daily (M-F) IDT meeting to assess current interventions and discuss

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F 309	Continued From page 30 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 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 (PT) 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 propelled herself independently but needed constant curing to time, place and room location. In addition, the care plan identified R73 was incontinent of urine, had impaired ADL's related to diagnosis of dementia, cerebral infarction (CVA, stroke) and needed extensive assist of of one with dressing, bathing and grooming. Further, the	F 309	alternate possible intervention and/or recommendations for changes to Emergency Care Plan. Results will be reviewed by the QA/QI committee for further recommendations. Further system revision and staff education will be provided if indicated by QA/QI committee. The Director of Nursing will be responsible for monitoring this for on-going compliance. Date: 10/30/17	

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care plan indicated R73 was at risk for impaired mobility related to diagnosis of cerebral infarction, right sided weakness (hemi paresis) and needed extensive assist of one with transfers, was independent with bed mobility and needed assistance of one with a rolling walker.

During observation 8/29/17, at 6:54 p.m. R73 was seated in a standard wheelchair in the South wing hallway. R73 was leaning to the right side with her shoulder against the rear frame of the chair, propelling the wheelchair using both feet. R73 was mumbling non sensical words, and had a furrowed brow facial expression.

During subsequent observation on 8/30/17, at 9:22 a.m. R73 was lying in bed in her room. Nursing assistant (NA)-J entered the room to help R73 with morning cares. NA-J put R73's socks on, and proceeded to assist R73 to sit up in bed. NA-J assisted and strapped R73 into a mechanical standing lift, and assisted her to a standing position from her bed. NA-J wheeled R73 in the mechanical lift to the bathroom, removed her visibly soiled incontinence product and seated her on the toilet. R73 did not void when seated on the toilet. NA-J used a wet washcloth to wash R73's face, back, arms and perineal area. R73 made no attempts to participate in her bathing. NA-J stated R73 used to be ambulatory and transferred on her own, however, R73 sustained a stroke a few months ago and now required a mechanical lift for transfers, used a wheelchair for mobility and was unable to ambulate anymore.

During interview on 8/29/17, at 1:41 p.m. family member (FM)-A stated she was the person who would be notified of a change in condition, or

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accident, with R73. FM-A stated a few months ago (R73) developed stroke symptoms and the facility attempted to call her, however, just left a message on her phone about her sudden change in condition. The nursing home thought she had a stroke and wanted her to call them back. They did not tell her she had not been sent the hospital. FM-A stated she did not receive this message until several hours later. When she called the facility back, they had not sent (R73) to the hospital for these symptoms. FM-A stated she told staff to send R73 to the emergency room for treatment immediately and thought if someone had stroke symptoms they should have gone in right away. FM-A stated she was unaware why the facility did not send her immediately to the hospital, adding she was upset. The facility waited too long to send (R73) to the emergency room for treatment.

R73's undated Resident Face Sheet indicated family member (FM)-A was R73's emergency contact, responsible party and the person to call if a change in condition. Further, the sheet indicated FM-B was the secondary contact.

Review of R73's Provider Order for Life Sustaining Treatment (POLST) dated and signed by R73's certified nurse practitioner (CNP)-A on 10/14/15, identified R73 had do not resuscitated or intubated (DNR/DNI) on the POLST. A section labeled, "Goals of Treatment," included directions to be implemented if R73, "has pulse and/or is breathing," and identified R73 had "Comfort Care," with several options that could be selected in accordance with R73's wishes. There was a box to check or not check next to each of these areas, to clarify their wishes of comfort care. The areas on the form were:

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- "Avoid calling 911, call [blank line to fill in] instead,"
- "If possible, do not transport to ER [emergency department] ...," and,
- "If possible, do not admit to the hospital from the ER ..."

However, all of these options were left unchecked, identifying R73 wanted these actions implemented. Further, R73's POLST identified an option that was checked which identified, "Limit Interventions and Treat Reversible Conditions," which was described as, "Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions," further identifying, "Transport to ER presumed." The POLST was signed by R73, however, was undated.

R73's progress note dated 6/10/17, at 18:23 indicated, "Noted [R73] was difficult to rouse before dinner at 1615. Noted resident with unsteady gait, RT [right] facial droop, RT pupil non-reactive, slurred/slow speech, and bilateral hand/foot strength WNL [with in normal limits]. BP [blood pressure] 149/52, P [pulse] 73, RR [respiration rate] 18, Sp 02 [oxygen saturation in blood] 97% on RA [room air] and T [temperature] 96.7. Family notified writer at 1815 that they want resident sent into the hospital to get checked out."

A First Light Health System Ambulance Report dated 6/10/17, indicated dispatch was called at 18:21 and the primary impression was neuro-stroke/CVA. R73 arrived at the hospital on 6/10/17, at 18:50 via ambulance, 2 hours and 35 minutes after R73's significant change in condition was identified at the nursing home.

R73's ED (emergency department) to

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F 309	Continued From page 34 Hosp-Admision report dated 6/10/17, at 6:49 p.m. identified R73 had a primary diagnosis of CVA (stroke). The report indicated she was a 75 year old female with a history of dementia, meningioma (non-cancer brain tumor that arises from the membranes to the spinal cord), history of CVA's, DM (diabetes mellitus), hyperlipidemia (high cholesterol), htn (hypertension) and was admitted with probable CVA. The report indicated her primary deficit was confusion with speech difficulty and will continue Plavix (blood thinner) for secondary prevention. PT/OT and speech therapy were ordered at the hospital. In addition, the report indicated a CT (cat scan) of the head was done and compared to a previous CT completed on 10/09/15, and the findings indicated CSF (cerebral spinal fluid) spaces with no hydrocephalus (fluid in the brain), atrophy (waste away). The CT scan impression indicated no acute intracranial abnormality, stable atrophy and chronic small vessel ischemic (restriction of blood) change, stable anterior lateral left cerebellar meningioma and chronic right frontal lobe infarct (stroke). A Progress Note on the ED to Hosp-Admission report dated 6/11/17, R73 was admitted to the hospital on 6/10/17, for a CVA. A First Light Health System Hospital Discharge Summary dated 6/12/17, completed by medical doctor (MD)-A indicated she had an acute CVA. A Brief HPI/PE (history of present illness/physical exam) indicated (R73) was a 75 year old female with history of dementia, meningioma, prior CVA, MD, hyperlipidemia and hypertension presented to the ER with increased confusion and difficulty with speech. Lives in SNF (skilled nursing facility) due to dementia. The DNR/DNI but family wants treatment for conditions that may be reversible. Pt (patient) took nap at 1430 today. Was difficult	F 309		

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F 309	Continued From page 35 to arouse at 1630 and once she was awake staff noted a change. It took time to contact family and once family was contacted pt was brought to ER (POLST listed comfort care but family wanted treatment for potentially reversible condition). By that time, too much time had passed from the last known normal time so tPA (tissue plasminogen activator that is ischemic stroke treatment that dissolves the clot and improves blood flow to the part of the brain deprived of blood flow) was not an option. Pt has significant dementia making history and exam difficult. Denies any f/c (fevers/chills), chest pain, sob (shortness of breath), cough or trouble going to the bathroom (unclear how reliable pt is.) no other concerns. A First Light Health System Mora, Minnesota Physician Criteria for tPA Use In Stroke guidelines last revised 2/11/10, indicated the following Inclusion Criteria: -Clearly defined time of onset of symptoms -tPA can be given within 3 hours of symptom onset -Patients over 18 -The patient's symptoms are clearly consistent with acute ischemic stroke with measurable deficit A Senior Care Transitions Long Term Care Visit dated 6/15/17, completed by certified nurse practitioner (CNP)-A indicated she was seen for a long term care visit and her primary diagnosis was acute CVA. The HPI (history of present illness) on the report indicated she was a "75 year old female with past medical history significant for dementia, old CVA with right side weakness, diabetes mellitus, meningioma and hypertension. She felt ill on 6/10/17 and laid down for nap. When she awoke, she had increased confusion,	F 309		

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unstable gait, and difficulty speaking. She was brought to ED for evaluation and felt to have had an acute CVA. She stabilized and returned to St. Clare on 6/12/17. She continues to have deficits in speech, difficulty swallowing and increased confusion. She is on mechanical soft diet with honey thickened liquids. She is wheelchair bound, gait and balance unstable." The report indicated R73 returned to the nursing home following an acute CVA, with primary deficits in cognition, speech and swallow and referrals were made to PT/OT/SLP. R73 also had a diet changed to honey-thick liquids, mechanical soft.

A Speech Therapy Plan Of Care Initial Assessment dated 6/14/17, completed by ST-A indicated R73 was seen for expressive and receptive aphasia. The assessment indicated her prior level of communication was minimal assist and able to understand communication in a structured conversations with both familiar and unfamiliar communication partners. Her current level of communication had changed and she needed maximum assistance with consistent, maximal cues, was able to follow simple directions and respond to simple yes and no questions.

A Physical Therapy Initial Assessment dated 6/13/17, completed by PT-A indicated that prior to her CVA and after the following deficits were identified:
-gait 150 ft. (feet) prior with modified independence (assistive device or extra time needed), currently walks 100 ft. with contact guard assist (contact with patient due to unsteadiness).
-transfers she went from modified independence to supervision and needing verbal cures

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-falls she went from moderate risk to high risk of falls
The assessment further indicated R73's goal was to ambulate 100 ft with contact guard assist and front wheeled walker with right neglect. The end of goal status indicated her goal was not met and the patient ambulates 100 ft with minimal assistance and front wheeled walker in order to complete functional mobility.

An Occupational Therapy Progress and Discharge Summary dated 6/26/17, completed by OT-A indicated prior to her stroke R73 needed set up assist with self care, supervision with hygiene, partial to minimal assist with toileting. The assessment indicated that her current level on 6/26/17, R73 now required supervision and verbal cues with eating and moderate assistance with toileting.

During interview 8/30/17, at 8:02 a.m. registered nurse (RN)-B stated she was the clinical manager and MDS coordinator. RN-B stated that R73's FM-A wanted to make sure if anything happened to (R73) that was reversible she wanted her to be hospitalized FM-A has told us this multiple times.

During interview 8/30/17, at 11:41 a.m. the director of nursing (DON) stated when R73 woke up on 6/10/17, and showed symptoms of a stroke she should have been sent her to emergency department right away. It was her understanding that FM-A would want her sent in right away and staff should not have waited for FM-A to call back. The DON stated (R73) she was walking before her stroke, and feeding herself. Now she needs a wheelchair and supervision with eating. The DON further stated she was not aware the licensed practical nurse (LPN)-C waited so long

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for FM-A to call the facility back, and was unaware of the ED discharge summary identifying it was "too late" to treat (R73) with tPA because she was not sent in right away by the nursing home.

On 8/30/17, at 12:20 p.m. a message was left with MD-A (who was not her primary physician) at First Light Health System who completed the hospital discharge summary on 6/12/17. MD-A did not return the phone call.

During interview 8/31/17, at 9:00 a.m. the DON stated LPN-C was the nurse working on 6/10/17, and was R73's nurse. The DON stated she spoke to LPN-C and he stated the reason why he waited for the family to return the call instead of sending her in was because the nurse practitioner (CNP)-A told him to wait and see what the family wanted to do first. LPN-C stated he could not remember if he contacted the secondary family contact.

During interview 8/31/17, at 9:12 a.m. CNP-A stated on 6/10/17, LPN-C called her and told her the symptoms R73 was having. CNP-A stated based on past conversation with the FM-A they only wanted things treated that were reversible and wanted (R73) sent in for things like an infection and if it was a chronic condition she didn't want her sent in. CNP-A further stated (R73) had a brain tumor and chronic abdominal pain. FM-A was not treating that so she assumed they would not want her sent in when she was having stroke symptoms. The CNP-A stated FM-A was upset that she was not sent in right away, and stated, "I knew she was upset since the day it happened, I am well aware she is upset."

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During interview 8/31/17, at 10:46 a.m. with the facility medical director (who was not R73's primary physician) reviewed R73's POLST and hospitalization on 6/10/17. The facility medical director stated if a resident has a POLST like hers and was having stroke symptoms she should have been sent to the emergency room right away and not wait for family to return the call. The medical director stated if she had pneumonia or something that was not so urgent they could have waited. The medical director reviewed the emergency department note and stated MD-B was the emergency room physician. "Reading MD-B note and was sleeping at 1430 you have to assume this was the last time [R73] had no CVA symptoms. When she got to the ED they decided not treat with tPA because too much time had passed. The medical director stated a stroke could be a reversible condition and it would make sense to send her to the ED right away."

During interview 8/31/17, at 11:19 a.m. the DON stated during an emergency situation she would expect the facility to call the physician or nurse practitioner, and family. If they were unable to contact the primary contact, they should call the secondary contact and then just send the resident in. The DON stated they should not have waited for the family to call back and should have just sent her in. The DON stated they don't have a specific policy stating this but this was their protocol.

During interview 8/31/17, at 12:57 p.m. LPN-C stated he was R73's nurse on 6/10/17, and when she woke up he noted a facial droop and paralysis so he called the CNP-A, who told him

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F 309	Continued From page 40 she did not think the family would want her to go to the ED because of her diagnosis or something. LPN-C stated he called (FM)-A and left a message. When FM-A called back she told LPN-C to send her in right away. LPN-C stated he was unable to recall the events after calling FM-A, but had not received a call back right away and was unsure if he attempted to call the secondary contact FM-B. LPN-C stated even though so much time had passed, he had not heard from FM-A nor did he recall calling CNP-A again about not being able to reach FM-A, because CNP-A did not seem too concerned. On 8/31/17, at 1:12 p.m. a call was placed to the ED and a message was left for MD-B. MD-B did not return the call. During interview 8/31/17, at 1:33 p.m. CNP-A stated she can not recall if LPN-C called her on 6/10/17, about not being able to reach (R73's) FM-A or FM-B right away. CNP-A stated even if LPN-C called me again, she would not have not changed her decision because she was under the impression FM-A did not want to treat (R73). During interview 8/31/17, at approximately 2:45 p.m. NA-B stated prior to R73's stroke she did not need much assistance from staff to brush her hair, brush teeth and dress and undress herself. NA-B further stated she fed herself and knew the schedule of activities, would voluntarily assist staff but pushing resident wheel chairs to and from activities and meals when residents requested, was happy and joked around. NA-B stated, "Since her stroke she seems sad, down, brushes off conversations and it seems that she knows life is now different." NA-B further stated, "She also seems embarrassed, while [R73]	F 309		

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doesn't ask for help and when she is assisted with care, [R73's] expressions appears that she doesn't like it."

During interview 8/31/17, at approximately 3:00 p.m. NA-C after R73's stroke she seems more sad. NA-C stated that prior to the stroke R73 dressed and groomed herself with occasional assist to tuck in a blouse. NA-C stated since the stroke, R73 needs total assistance with all her daily needs.

During interview 8/31/17, at 3:16 p.m. FM-A stated the facility called her on 6/10/17, and left her a message. The facility did not call FM-B who was (R73's) secondary emergency contact.

Although R73 had a change in condition on 6/10/17, with stroke symptoms, the facility failed to provide prompt emergency treatment by not sending R73 immediately to the ED following R73's POLST, which outlined R73's wanted treatment for reversible conditions. The facility's failure to respond in a timely manner, prevented R73 from receiving tPA medication, which is time sensitive and must be administered within 3 hours to reverse stroke symptoms. As a result of not receiving this medication, R73 had a significant change in her ADL's and was dependent upon staff, resulting in actual harm to R73.

A facility policy Change In Condition reviewed 9/15/08, indicated, "Except in medical emergency or when a resident is incompetent, the facility must consult with the resident immediately and notify the residents's physician, and if known the resident's legal representative or interested family member when there is: a) A

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F 309	Continued From page 42 change in resident's physical, mental or psychosocial status. b) A need to alter treatment significantly. c) A decision to transfer or discharge the resident from the facility." The policy further indicated to notify the family significant other when there is a change in status of a resident, the "RN or designee will: 1. Notify the first designated contact person 2. If unable to locate this individual, the next designated individual will be contacted." A facility policy Emergency Care undated indicated licensed nursing staff will provide care for residents in an emergency situation and the procedure would be to stay with the resident while 911 would be called, give address, nature of the problem and do not hang up until told to do so. And in a non-life threatening emergency to give emergency care, notify physician, if needed call for ambulance and notify family. A facility policy St. Clare Living Community Of Mora Policy and Procedure For Documentation Guidelines And Maintaining Legally Sound Health Record dated 1/2017, indicated under notification or communication that notification to the resident's physician, nurse practitioner or family is required. When a discussion with the resident's family occurs regarding care of the resident, all such communication (including attempts at notification) have to be charted. Include the time and method of all communications. The entry has to include any orders received or responses, the implementation of such orders if any and the resident's response. Messages left on answering machines should be limited to a request to return call and does not meet the definition of notification. Make sure to report to the the next shift that a message was left with the family and	F 309		

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F 309	Continued From page 43 that they need to follow up with another call. A facility policy St. Clare Living Community dated 3/8/11, indicated under "Policy: Each resident will have a completed POLST form included in their medical record. This form will be completed based on wishes of the resident and/or appointed representative agent. The form will be revived regularly and kept current. Purpose: To provide the nursing staff, physicians, family and all others involved with the care of the resident, a written plan that states the resident's wishes about how they want to manage their treatment and care. This form will address their wishes not only related to the end of life, but also the quality of life they desire while living with a chronic illness."	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation,interview and document review, the facility failed to ensure all personal grooming was provided to 1 of 3 residents (R73) reviewed for activities of daily living (ADL's) who was dependant on staff for cares. 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.	F 312	F312 ADL Care Provided for Dependent Residents It is the policy of St. Clare Living Community to provide care and services by qualified persons in accordance with each resident s written plan of care. For resident R-73 care plan and care assignment sheet reviewed and revised on 9/27/17. For other dependent residents affected by this practice, an audit on facial hair care plans and care assignment sheets was completed on 9/29/17. The policy for facial hair/shaving has been	10/30/17

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F 312	Continued From page 44 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. During observation on 8/28/17, at 1:20 p.m. R73 was observed to be sitting in her wheelchair in the day room with multiple visible facial hairs from her chin down to the middle of her neck approximately 3/8 inch in length. During observation 8/29/17, at 12:26 p.m. R73 was sitting in her wheelchair in the south hall by the doorway with visible facial hair on her face and chin. During interview 8/29/17, at 6:45 p.m. trained medical assistant (TMA)-A stated R73 is pretty good with receiving cares she might say no to toileting but she will allow us to do grooming. In subsequent interview at 7:06 p.m. TMA-A stated when looking at R73's facial hairs something could have been done with the facial hairs. TMA-A stated R73 should have been shaved on her bath day. Review of the Bath Book indicated that R73 received her bath on Friday 8/25/17. During observation and interview 8/30/17, at 9:22 a.m. R73 was lying in bed with visible facial hair from her chin to the middle of her neck. Nursing assistant (NA)-J entered the room. NA-J put R73's socks on proceeded to sit R73 up in bed. She brought a standing lift to R73's bed and	F 312	reviewed by IDT. Direct Care staff members have been trained as it relates to their respective roles and responsibilities regarding the facial hair/shaving policy on 10/12/17. Facial hair/shaving audits will be conducted 3 times per week for 30 days, weekly for 30 day, monthly for 3 months and randomly thereafter with results reported to QA Committee for review and further recommendation. Further system revision and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance. Compliance date 10/30/17	

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F 312	Continued From page 45 attached the straps under her arms and lifted her up in a standing position. NA-J wheeled the lift to the bathroom, removed R73's incontinent pad and lowered her onto the toilet. NA-J washed R73's face, back, arms, legs and peri area and dressed her. NA-J then lifted R73 back up with the standing lift and lowered into her wheelchair. NA-J stated all that was left was to comb the hair. NA-J combed R73's hair and wheeled her into the hallway. NA-J did not provide oral care or shave her facial hair. During interview 8/30/17, at 11:39 a.m. the director of nursing (DON) stated the staff should be removing facial hair as they are doing cares and it could also be done during there bath or if staff noticed it [facial hair]. The DON further indicated oral care should be done with a.m. and p.m. cares. The DON stated a.m. cares were done when staff got residents up for the morning and that she should have been shaved and received oral care. The DON stated she would let the staff know to shave her and do oral cares. During interview 8/30/17, at 1:59 p.m. NA-J stated the DON inforrmed her that R73 did not receive oral care and was not shaved with a.m. cares when I got her dressed in the morning. I completed these cares after her lunch today when I was informed by the DON. NA-J further stated she completes these cares after lunch. A facility policy was requested but was not received.	F 312		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities	F 412		10/30/17

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F 412	Continued From page 46 The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document 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	F 412	F412 Routine/Emergency Dental Services It is the policy of St. Clare Living Community to provide routine and emergency in accordance with each resident plan of care. For resident #R90 care plan reviewed and revised on 9/27/17. Education has been provided for Licensed Nursing and NA/R s staff members regarding dental services and emergency dental services on 10/3/17,	

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F 412	Continued From page 47 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 7:41 a.m. R90 was seated in the dining room eating buttered toast and hot cereal. R90 again, did not have any visible teeth or dentures on her upper palate stating, "my top one's not [in]," when asked about her teeth. R90 denied having any trouble chewing, and consumed nearly 100% of the meal. R90's progress note dated 8/9/17, identified R90's, "top dentures not located this [morning]. 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. When interviewed on 8/30/17, at 8:06 a.m.	F 412	and 10/12/17. For all residents with dentures who may be affected by this practice an audit for ill fitting, broken, or missing dentures was completed on 9/29/17. The policy for dental services and emergency dental services has been reviewed by the IDT. Resident denture audits will be completed weekly for one month, monthly for three months, randomly thereafter to ensure compliance with results to QA Committee for review and further recommendations. Compliance Date 10/30/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING ______ B. WING ______	08/31/2017

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

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F 412	Continued From page 48 nursing assistant (NA)-D stated R90 typically wore, "top and bottom," dentures, however, the top set had been missing, "[a] little over a month now." NA-D stated she thought nursing had addressed it with family and were, "seeing if they can get to a dentist." 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. When interviewed on 8/30/17, at 9:15 a.m. LPN-A stated she thought R90's upper denture had been missing, "for a month now," and family was aware as, "somebody's called family about this." LPN-A reviewed R90's medical record and stated it lacked any follow up or direction on how family wanted to proceed with the missing dentures, so she would contact the responsible party. During subsequent interview on 8/30/17, at 12:39 p.m. LPN-A stated she spoke with R90's responsible party who voiced they, "had not been updated yet," on R90's missing teeth. LPN-A stated R90's responsible party wanted her seen by the dentist for new dentures to be cast. LPN-A added she was unaware why it had not been addressed prior, "I don't know why it wasn't followed up on." During interview on 8/31/17, at 9:13 a.m. the director of nursing (DON) stated missing dentures should be reported to the family so staff could start the process for getting new ones made adding R90's dentures should have been addressed when they were first identified to be missing.	F 412		

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	245291	A. BUILDING ______ B. WING ______	08/31/2017

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

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F 412	Continued From page 49 A facility Denture Care and Replacement policy dated 11/7/16, identified a section labeled, "Procedure for Reporting and Addressing Damaged or Missing Dentures," and directed staff to report the missing dentures to the nurse manager. Further, the policy directed, "within 3 days," the facility would refer the resident for dental services.	F 412		

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	245291	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/31/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Clare Living Community of Mora was found not in 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	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/29/2017

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

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K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St. Clare Living Community of Mora is a 1-story building with small partial basement. The original building was constructed in 1969 and additions constructed in 1999. The 1969 building is of type II(111) construction and the 1999 building is type V(111) construction. To the north a single story type V(111) assisted living facility also adjoins and is separated by 2 hour construction with a 90 minute rated, self closing door. The addition of Type V(111) construction opened to the west in 2005 previously survey separately can now be surveyed as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.	K 000		

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

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	245291	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/31/2017**

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

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K 000	Continued From page 2 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.	K 000		
K 347 SS=D	NFPA 101 Smoke Detection 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: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code, (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 National Fire Alarm Code (2010) section 17.6.3.1.1 This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 10 of the 65 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 08/31/2017, observation and staff interview revealed no smoke detector in the Elevator Mechanical Room. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 347	K347 NFPA 101 Smoke Detection St. Clare Living Community of Mora does comply with the NFPA 101 Smoke Detection under the 2012 Existing Building requirements. During the tour with the Fire Marshall on 8/31/17 the Elevator Mechanical Room was inspected. It was noted that there was no Smoke Detection located within the mechanical room. The Administrator has scheduled with the Summit Company to add to our detection system one smoke detector and one sprinkler head in compliance with the NFPA 101 Life Safety Code (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 National Fire Alarm Code (2010) section 17.6.3.1.1 no later than October 30, 2017. The Administrator will be responsible for ongoing compliance with NFPA 101 Life Safety Code (2012) and PFPA 72 National	10/30/17

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K 347	Continued From page 3	K 347	Fire Alarm Code (2010). The correction of this deficiency will be reported to the QA committee at their October 2017 Meeting. Date of Correction: 10/30/17	
K 351 SS=F	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to install sprinkler heads in accordance with the 2012 edition of the Life Safety Code (NFPA 101) sections 19.3.5.1, 9.7.1.1 and the 2010 edition of NFPA 13, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of an undetermined amount of staff and visitors.	K 351	K351 NFPA 101 Sprinkler System - Installation St. Clare Living Community of Mora does comply with the NFPA 101 Smoke Detection under the 2012 Existing Building requirements. During the tour with the Fire Marshall on 8/31/17 the Elevator Mechanical Room was inspected. It was noted that there was no	10/30/17

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K 351	Continued From page 4 Findings include: On the facility tour between 8:00 am to 1:00 pm on 08/31/2017, observations and staff interview revealed there was no sprinkler head installed in the Elevator Mechanical Room. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 351	sprinkler head located within the room. The Administrator has scheduled with the Summit Company to add to our detection system one smoke detector and one sprinkler head in compliance with the NFPA 101 Life Safety Code (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 National Fire Alarm Code (2010) section 17.6.3.1.1 no later than October 30, 2017. The Administrator will be responsible for ongoing compliance with NFPA 101 Life Safety Code (2012) and PFPA 72 National Fire Alarm Code (2010). The correction of this deficiency will be reported to the QA committee at their October 2017 Meeting. Date of Correction: 10/30/17	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______	K 353		9/22/17

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K 353	Continued From page 5 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff, it was determined that the Sprinkler Suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2012), Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could cause a delay in extinguishing a fire affecting the safety of an undetermined amount of staff and visitors. Findings Include: During documentation review between 8:00 AM and 1:00 PM on 08/31/2017, documentation review and staff interview revealed the last sprinkler test was performed 07/18/2016 and 3 of the 4 quarterly sprinkler inspections were not been completed. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 353	K353 NFPA 101 Sprinkler System □ Maintenance and Testing At St. Clare Living Community of Mora Sprinkler Systems □ Maintenance and Testing are conducted in accordance with NFPA 25, Standard for the Inspection, testing, and maintaining of Water-based Fire Protection System. We maintain standard documentation of type of test and/or maintenance of the system. On 8/31/17 during the tour of the facility the Fire Marshall noticed that the last annual inspection was conducted on 7/18/2016 and that there was no documentation for 3 of 4 quarterly flow test. The Administrator had contacted the Summit Company on 8/31/17 to schedule the annual inspection. This inspection was completed on 9/22/17. The Summit employee also conducted the Quarterly Inspection and has trained St. Clare□s new Environmental Service Director on the correct procedures for doing the quarterly inspection going forward. The Administrator will be responsible of on-going monitoring for compliance with NFPA 101 Sprinkler System □ Maintenance and Testing. The correction of this deficiency will be reported to the QA committee at their October 2017 Meeting.	

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K 353	Continued From page 6	K 353	Date Corrected: 9/22/17	
K 901 SS=D	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories 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. Chapter 4 (NFPA 99) 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 Facility Administrator and the Environmental Services Supervisor.	K 901	K901 NFPA 101 Fundamentals □ Building System Categories Fundamentals □ Building System Categories: Building Systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Upon review on 8/31/17 the facility lacked documentation that an appropriate Building Risk Assessment was completed to meet the Category 1 through 4 requirements as detailed in NFPA 99. St. Clare Living Community of Mora is in the process of conducting a building risk assessment designed to meet the Category 1 □ 4 requirements as detailed in NFPA 99 of all systems and rooms to be completed no later than October 27, 2017. Once completed the risk assessment will be reviewed an updated	10/27/17

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K 901	Continued From page 7	K 901	annually in October of each year. The Administrator will be responsible of on-going monitoring for compliance with NFPA 99 requirements to meet Category 1-4. The correction of this deficiency will be reported to the QA committee at their October 2017 Meeting. Date corrected: 10/27/17	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00814	A. BUILDING: ______ B. WING ______	08/31/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00814	A. BUILDING: ______ B. WING ______	08/31/2017

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/28/17 to 8/31/17, surveyors from the Minnesota Department of Health (MDH) visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. 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). 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. During observation on 8/28/17, at 1:20 p.m. R73 was observed to be sitting in her wheelchair in the	2 565	Correction Completed	10/30/17

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2 565	Continued From page 3	2 565		

day room with multiple visible facial hair on her chin down to the middle of her neck approximately 3/8 inches in length.

During observation 8/29/17, at 12:26 p.m. R73 was sitting in her wheelchair in the south hall by the doorway with visible facial hair on her face and chin.

During interview 8/29/17, at 6:45 p.m. trained medical assistant (TMA)-A stated R73 is pretty good with receiving cares she might say no to toileting but she will allow us to do grooming. In subsequent interview at 7:06 p.m. TMA-A stated looking at R73's facial hairs "Oh, there is something that could be done with that she should have been shaved on . That is done on her bath day."

Review of the Bath Book indicated that she received her bath on Friday 8/25/17.

During observation and interview 8/30/17, at 9:22 a.m. R73 was lying in bed with visible facial hair from her chin to the middle of her neck. Nursing assistant (NA)-J entered the room. NA-J put R73's socks on proceeded to sit R73 up in bed she brought a standing lift to her bed and attached the straps under her arms and proceeded to lift her up in a standing position with the lift. NA-J then wheeled the lift to the bathroom removed her incontinent pad and lowered her onto the toilet. NA-J then proceeded to wash her face, back arms and legs and peri area and dressed her. NA-J then lifted R73 back up with the standing lift and lowered into her wheelchair. NA-J then stated all we have left to do now is comb your hair. NA-J combed R73's hair and then wheeled her into the hallway. NA-J did not provide oral care or shave her facial hair.

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2 565	Continued From page 4 During interview 8/30/17, at 11:39 a.m. the director of nursing (DON) stated the staff should be removing facial hair as they are doing cares and it could also be done during there bath or if they notice it. The DON further indicated oral care should be done with a.m. and p.m. cares. The DON stated a.m. cares is when they get the residents up for the morning and that she should have been shaved and received oral care. The DON stated she will let the staff know to shave her and do oral cares. During interview 8/30/17, at 1:59 p.m. NA-J stated the DON informed her that R73 did not receive oral care and was not shaved with a.m. cares when I got her dressed in the morning. I completed these cares after her lunch today when I was informed by the DON. NA-J further stated she completes these cares after lunch. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementation of the care plan, then complete audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming,	2 920		10/30/17

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2 920	Continued From page 5 and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation,interview and document review, the facility failed to ensure all personal grooming was provided to 1 of 3 residents (R73) reviewed for activities of daily living (ADL's) who was dependant on staff for cares. 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. During observation on 8/28/17, at 1:20 p.m. R73 was observed to be sitting in her wheelchair in the day room with multiple visible facial hairs from her chin down to the middle of her neck approximately 3/8 inch in length. During observation 8/29/17, at 12:26 p.m. R73 was sitting in her wheelchair in the south hall by the doorway with visible facial hair on her face and chin. During interview 8/29/17, at 6:45 p.m. trained medical assistant (TMA)-A stated R73 is pretty	2 920	Correction Completed	

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2 920	Continued From page 6	2 920		

good with receiving cares she might say no to toileting but she will allow us to do grooming. In subsequent interview at 7:06 p.m. TMA-A stated when looking at R73's facial hairs something could have been done with the facial hairs. TMA-A stated R73 should have been shaved on her bath day.

Review of the Bath Book indicated that R73 received her bath on Friday 8/25/17.

During observation and interview 8/30/17, at 9:22 a.m. R73 was lying in bed with visible facial hair from her chin to the middle of her neck. Nursing assistant (NA)-J entered the room. NA-J put R73's socks on proceeded to sit R73 up in bed. She brought a standing lift to R73's bed and attached the straps under her arms and lifted her up in a standing position. NA-J wheeled the lift to the bathroom, removed R73's incontinent pad and lowered her onto the toilet. NA-J washed R73's face, back, arms, legs and peri area and dressed her. NA-J then lifted R73 back up with the standing lift and lowered into her wheelchair. NA-J stated all that was left was to comb the hair. NA-J combed R73's hair and wheeled her into the hallway. NA-J did not provide oral care or shave her facial hair.

During interview 8/30/17, at 11:39 a.m. the director of nursing (DON) stated the staff should be removing facial hair as they are doing cares and it could also be done during there bath or if staff noticed it [facial hair]. The DON further indicated oral care should be done with a.m. and p.m. cares. The DON stated a.m. cares were done when staff got residents up for the morning and that she should have been shaved and received oral care. The DON stated she would let the staff know to shave her and do oral cares.

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2 920	Continued From page 7 During interview 8/30/17, at 1:59 p.m. NA-J stated the DON informed her that R73 did not receive oral care and was not shaved with a.m. cares when I got her dressed in the morning. I completed these cares after her lunch today when I was informed by the DON. NA-J further stated she completes these cares after lunch. A facility policy was requested but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding timely completion of grooming on residents, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21325	Correction Completed	10/30/17

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21325	Continued From page 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 7:41 a.m. R90 was seated in the dining room eating buttered toast and hot cereal. R90 again, did not have any visible teeth or dentures on her upper palate stating, "my top one's not [in]," when asked about her teeth. R90 denied having any trouble chewing, and consumed nearly 100% of the meal.

R90's progress note dated 8/9/17, identified R90's, "top dentures not located this [morning].

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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.

When interviewed on 8/30/17, at 8:06 a.m. nursing assistant (NA)-D stated R90 typically wore, "top and bottom," dentures, however, the top set had been missing, "[a] little over a month now." NA-D stated she thought nursing had addressed it with family and were, "seeing if they can get to a dentist."

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.

When interviewed on 8/30/17, at 9:15 a.m. LPN-A stated she thought R90's upper denture had been missing, "for a month now," and family was aware as, "somebody's called family about this." LPN-A reviewed R90's medical record and stated it lacked any follow up or direction on how family wanted to proceed with the missing dentures, so she would contact the responsible party. During subsequent interview on 8/30/17, at 12:39 p.m. LPN-A stated she spoke with R90's responsible party who voiced they, "had not been updated yet," on R90's missing teeth. LPN-A stated R90's responsible party wanted her seen by the dentist for new dentures to be cast. LPN-A added she was unaware why it had not been addressed

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21325	Continued From page 10 prior, "I don't know why it wasn't followed up on." During interview on 8/31/17, at 9:13 a.m. the director of nursing (DON) stated missing dentures should be reported to the family so staff could start the process for getting new ones made adding R90's dentures should have been addressed when they were first identified to be missing. A facility Denture Care and Replacement policy dated 11/7/16, identified a section labeled, "Procedure for Reporting and Addressing Damaged or Missing Dentures," and directed staff to report the missing dentures to the nurse manager. Further, the policy directed, "within 3 days," the facility would refer the resident for dental services. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding timely follow up with missing dental appliances, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning.	21810		10/30/17

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This right is limited where the service is not reimbursable by public or private resources.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide timely emergency medical services for 1 of 1 residents (R73) who had stroke symptoms and subsequent stroke which caused physical impairment that limited R73's ability to complete activities of daily living (ADL's), that resulted in actual harm.

Correction Completed

Findings include:

R73's quarterly Minimum Data Set (MDS) dated 6/1/17, indicated she was severely cognitively impaired, needed staff supervision with assistance of one for activities of daily living (ADLs), she needed set up assistance with eating and physical assistance of one for bathing. There were no other limitations of R73's ADL's during this assessment period.

R73's significant change MDS dated 6/21/17, identified the following changes in her activity of daily living (ADL) status: She now needed limited assistance of one with bed mobility, transfers, dressing and toileting. In addition, the MDS indicated she was totally dependent upon staff for toileting, ambulated only once or twice and needed staff supervision and assistance of one with eating. R73 remained severely cognitively impaired which was the same on 6/1/17.

R73's most recent Cognitive Care Area Assessment (CAA) dated 6/21/17, identified R73 had dementia with severely impaired decision

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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 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 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 (PT) 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 propelled herself independently but needed	21810		

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constant curing to time, place and room location. In addition, the care plan identified R73 was incontinent of urine, had impaired ADL's related to diagnosis of dementia, cerebral infarction (CVA, stroke) and needed extensive assist of of one with dressing, bathing and grooming. Further, the care plan indicated R73 was at risk for impaired mobility related to diagnosis of cerebral infarction, right sided weakness (hemi paresis) and needed extensive assist of one with transfers, was independent with bed mobility and needed assistance of one with a rolling walker.

During observation 8/29/17, at 6:54 p.m. R73 was seated in a standard wheelchair in the South wing hallway. R73 was leaning to the right side with her shoulder against the rear frame of the chair, propelling the wheelchair using both feet. R73 was mumbling non sensical words, and had a furrowed brow facial expression.

During subsequent observation on 8/30/17, at 9:22 a.m. R73 was lying in bed in her room. Nursing assistant (NA)-J entered the room to help R73 with morning cares. NA-J put R73's socks on, and proceeded to assist R73 to sit up in bed. NA-J assisted and strapped R73 into a mechanical standing lift, and assisted her to a standing position from her bed. NA-J wheeled R73 in the mechanical lift to the bathroom, removed her visibly soiled incontinence product and seated her on the toilet. R73 did not void when seated on the toilet. NA-J used a wet washcloth to wash R73's face, back, arms and perineal area. R73 made no attempts to participate in her bathing. NA-J stated R73 used to be ambulatory and transferred on her own, however, R73 sustained a stroke a few months ago and now required a mechanical lift for transfers, used a wheelchair for mobility and was

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21810	Continued From page 14 unable to ambulate anymore. During interview on 8/29/17, at 1:41 p.m. family member (FM)-A stated she was the person who would be notified of a change in condition, or accident, with R73. FM-A stated a few months ago (R73) developed stroke symptoms and the facility attempted to call her, however, just left a message on her phone about her sudden change in condition. The nursing home thought she had a stroke and wanted her to call them back. They did not tell her she had not been sent the hospital. FM-A stated she did not receive this message until several hours later. When she called the facility back, they had not sent (R73) to the hospital for these symptoms. FM-A stated she told staff to send R73 to the emergency room for treatment immediately and thought if someone had stroke symptoms they should have gone in right away. FM-A stated she was unaware why the facility did not send her immediately to the hospital, adding she was upset. The facility waited too long to send (R73) to the emergency room for treatment. R73's undated Resident Face Sheet indicated family member (FM)-A was R73's emergency contact, responsible party and the person to call if a change in condition. Further, the sheet indicated FM-B was the secondary contact. Review of R73's Provider Order for Life Sustaining Treatment (POLST) dated and signed by R73's certified nurse practitioner (CNP)-A on 10/14/15, identified R73 had do not resuscitated or intubated (DNR/DNI) on the POLST. A section labeled, "Goals of Treatment," included directions to be implemented if R73, "has pulse and/or is breathing," and identified R73 had "Comfort Care," with several options that could be selected	21810		

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in accordance with R73's wishes. There was a box to check or not check next to each of these areas, to clarify their wishes of comfort care. The areas on the form were:
- "Avoid calling 911, call [blank line to fill in] instead,"
- "If possible, do not transport to ER [emergency department] ...," and,
- "If possible, do not admit to the hospital from the ER ..."
However, all of these options were left unchecked, identifying R73 wanted these actions implemented. Further, R73's POLST identified an option that was checked which identified, "Limit Interventions and Treat Reversible Conditions," which was described as, "Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions," further identifying, "Transport to ER presumed." The POLST was signed by R73, however, was undated.

R73's progress note dated 6/10/17, at 18:23 indicated, "Noted [R73] was difficult to rouse before dinner at 1615. Noted resident with unsteady gait, RT [right] facial droop, RT pupil non-reactive, slurred/slow speech, and bilateral hand/foot strength WNL [with in normal limits]. BP [blood pressure] 149/52, P [pulse] 73, RR [respiration rate] 18, Sp 02 [oxygen saturation in blood] 97% on RA [room air] and T [temperature] 96.7. Family notified writer at 1815 that they want resident sent into the hospital to get checked out."

A First Light Health System Ambulance Report dated 6/10/17, indicated dispatch was called at 18:21 and the primary impression was neuro-stroke/CVA. R73 arrived at the hospital on 6/10/17, at 18:50 via ambulance, 2 hours and 35 minutes after R73's significant change in

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condition was identified at the nursing home.

R73's ED (emergency department) to Hosp-Admision report dated 6/10/17, at 6:49 p.m. identified R73 had a primary diagnosis of CVA (stroke). The report indicated she was a 75 year old female with a history of dementia, meningioma (non-cancer brain tumor that arises from the membranes to the spinal cord), history of CVA's, DM (diabetes mellitus), hyperlipidemia (high cholesterol), htn (hypertension) and was admitted with probable CVA. The report indicated her primary deficit was confusion with speech difficulty and will continue Plavix (blood thinner) for secondary prevention. PT/OT and speech therapy were ordered at the hospital. In addition, the report indicated a CT (cat scan) of the head was done and compared to a previous CT completed on 10/09/15, and the findings indicated CSF (cerebral spinal fluid) spaces with no hydrocephalus (fluid in the brain), atrophy (waste away). The CT scan impression indicated no acute intracranial abnormality, stable atrophy and chronic small vessel ischemic (restriction of blood) change, stable anterior lateral left cerebellar meningioma and chronic right frontal lobe infarct (stroke). A Progress Note on the ED to Hosp-Admission report dated 6/11/17, R73 was admitted to the hospital on 6/10/17, for a CVA.

A First Light Health System Hospital Discharge Summary dated 6/12/17, completed by medical doctor (MD)-A indicated she had an acute CVA. A Brief HPI/PE (history of present illness/physical exam) indicated (R73) was a 75 year old female with history of dementia, meningioma, prior CVA, MD, hyperlipidemia and hypertension presented to the ER with increased confusion and difficulty with speech. Lives in SNF (skilled nursing facility) due to dementia. The DNR/DNI but family wants

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treatment for conditions that may be reversible. Pt (patient) took nap at 1430 today. Was difficult to arouse at 1630 and once she was awake staff noted a change. It took time to contact family and once family was contacted pt was brought to ER (POLST listed comfort care but family wanted treatment for potentially reversible condition). By that time, too much time had passed from the last known normal time so tPA (tissue plasminogen activator that is ischemic stroke treatment that dissolves the clot and improves blood flow to the part of the brain deprived of blood flow) was not an option. Pt has significant dementia making history and exam difficult. Denies any f/c (fevers/chills), chest pain, sob (shortness of breath), cough or trouble going to the bathroom (unclear how reliable pt is.) no other concerns.

A First Light Health System Mora, Minnesota Physician Criteria for tPA Use In Stroke guidelines last revised 2/11/10, indicated the following Inclusion Criteria:
-Clearly defined time of onset of symptoms
-tPA can be given within 3 hours of symptom onset
-Patients over 18
-The patient's symptoms are clearly consistent with acute ischemic stroke with measurable deficit

A Senior Care Transitions Long Term Care Visit dated 6/15/17, completed by certified nurse practitioner (CNP)-A indicated she was seen for a long term care visit and her primary diagnosis was acute CVA. The HPI (history of present illness) on the report indicated she was a "75 year old female with past medical history significant for dementia, old CVA with right side weakness, diabetes mellitus, meningioma and hypertension. She felt ill on 6/10/17 and laid down for nap.

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When she awoke, she had increased confusion, unstable gait, and difficulty speaking. She was brought to ED for evaluation and felt to have had an acute CVA. She stabilized and returned to St. Clare on 6/12/17. She continues to have deficits in speech, difficulty swallowing and increased confusion. She is on mechanical soft diet with honey thickened liquids. She is wheelchair bound, gait and balance unstable." The report indicated R73 returned to the nursing home following an acute CVA, with primary deficits in cognition, speech and swallow and referrals were made to PT/OT/SLP. R73 also had a diet changed to honey-thick liquids, mechanical soft.

A Speech Therapy Plan Of Care Initial Assessment dated 6/14/17, completed by ST-A indicated R73 was seen for expressive and receptive aphasia. The assessment indicated her prior level of communication was minimal assist and able to understand communication in a structured conversations with both familiar and unfamiliar communication partners. Her current level of communication had changed and she needed maximum assistance with consistent, maximal cues, was able to follow simple directions and respond to simple yes and no questions.

A Physical Therapy Initial Assessment dated 6/13/17, completed by PT-A indicated that prior to her CVA and after the following deficits were identified:
-gait 150 ft. (feet) prior with modified independence (assistive device or extra time needed), currently walks 100 ft. with contact guard assist (contact with patient due to unsteadiness).
-transfers she went from modified independence to supervision and needing verbal cures

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-falls she went from moderate risk to high risk of falls
The assessment further indicated R73's goal was to ambulate 100 ft with contact guard assist and front wheeled walker with right neglect. The end of goal status indicated her goal was not met and the patient ambulates 100 ft with minimal assistance and front wheeled walker in order to complete functional mobility.

An Occupational Therapy Progress and Discharge Summary dated 6/26/17, completed by OT-A indicated prior to her stroke R73 needed set up assist with self care, supervision with hygiene, partial to minimal assist with toileting. The assessment indicated that her current level on 6/26/17, R73 now required supervision and verbal cues with eating and moderate assistance with toileting.

During interview 8/30/17, at 8:02 a.m. registered nurse (RN)-B stated she was the clinical manager and MDS coordinator. RN-B stated that R73's FM-A wanted to make sure if anything happened to (R73) that was reversible she wanted her to be hospitalized FM-A has told us this multiple times.

During interview 8/30/17, at 11:41 a.m. the director of nursing (DON) stated when R73 woke up on 6/10/17, and showed symptoms of a stroke she should have been sent her to emergency department right away. It was her understanding that FM-A would want her sent in right away and staff should not have waited for FM-A to call back. The DON stated (R73) she was walking before her stroke, and feeding herself. Now she needs a wheelchair and supervision with eating. The DON further stated she was not aware the licensed practical nurse (LPN)-C waited so long for FM-A to call the facility back, and was

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unaware of the ED discharge summary identifying it was "too late" to treat (R73) with tPA because she was not sent in right away by the nursing home.

On 8/30/17, at 12:20 p.m. a message was left with MD-A (who was not her primary physician) at First Light Health System who completed the hospital discharge summary on 6/12/17. MD-A did not return the phone call.

During interview 8/31/17, at 9:00 a.m. the DON stated LPN-C was the nurse working on 6/10/17, and was R73's nurse. The DON stated she spoke to LPN-C and he stated the reason why he waited for the family to return the call instead of sending her in was because the nurse practitioner (CNP)-A told him to wait and see what the family wanted to do first. LPN-C stated he could not remember if he contacted the secondary family contact.

During interview 8/31/17, at 9:12 a.m. CNP-A stated on 6/10/17, LPN-C called her and told her the symptoms R73 was having. CNP-A stated based on past conversation with the FM-A they only wanted things treated that were reversible and wanted (R73) sent in for things like an infection and if it was a chronic condition she didn't want her sent in. CNP-A further stated (R73) had a brain tumor and chronic abdominal pain. FM-A was not treating that so she assumed they would not want her sent in when she was having stroke symptoms. The CNP-A stated FM-A was upset that she was not sent in right away, and stated, "I knew she was upset since the day it happened, I am well aware she is upset."

During interview 8/31/17, at 10:46 a.m. with the

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facility medical director (who was not R73's primary physician) reviewed R73's POLST and hospitalization on 6/10/17. The facility medical director stated if a resident has a POLST like hers and was having stroke symptoms she should have been sent to the emergency room right away and not wait for family to return the call. The medical director stated if she had pneumonia or something that was not so urgent they could have waited. The medical director reviewed the emergency department note and stated MD-B was the emergency room physician. "Reading MD-B note and was sleeping at 1430 you have to assume this was the last time [R73] had no CVA symptoms. When she got to the ED they decided not treat with tPA because too much time had passed. The medical director stated a stroke could be a reversible condition and it would make sense to send her to the ED right away."

During interview 8/31/17, at 11:19 a.m. the DON stated during an emergency situation she would expect the facility to call the physician or nurse practitioner, and family. If they were unable to contact the primary contact, they should call the secondary contact and then just send the resident in. The DON stated they should not have waited for the family to call back and should have just sent her in. The DON stated they don't have a specific policy stating this but this was their protocol.

During interview 8/31/17, at 12:57 p.m. LPN-C stated he was R73's nurse on 6/10/17, and when she woke up he noted a facial droop and paralysis so he called the CNP-A, who told him she did not think the family would want her to go to the ED because of her diagnosis or something. LPN-C stated he called (FM)-A and left a

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message. When FM-A called back she told LPN-C to send her in right away. LPN-C stated he was unable to recall the events after calling FM-A, but had not received a call back right away and was unsure if he attempted to call the secondary contact FM-B. LPN-C stated even though so much time had passed, he had not heard from FM-A nor did he recall calling CNP-A again about not being able to reach FM-A, because CNP-A did not seem too concerned.

On 8/31/17, at 1:12 p.m. a call was placed to the ED and a message was left for MD-B. MD-B did not return the call.

During interview 8/31/17, at 1:33 p.m. CNP-A stated she can not recall if LPN-C called her on 6/10/17, about not being able to reach (R73's) FM-A or FM-B right away. CNP-A stated even if LPN-C called me again, she would not have not changed her decision because she was under the impression FM-A did not want to treat (R73).

During interview 8/31/17, at approximately 2:45 p.m. NA-B stated prior to R73's stroke she did not need much assistance from staff to brush her hair, brush teeth and dress and undress herself. NA-B further stated she fed herself and knew the schedule of activities, would voluntarily assist staff but pushing resident wheel chairs to and from activities and meals when residents requested, was happy and joked around. NA-B stated, "Since her stroke she seems sad, down, brushes off conversations and it seems that she knows life is now different." NA-B further stated, "She also seems embarrassed, while [R73] doesn't ask for help and when she is assisted with care, [R73's] expressions appears that she doesn't like it."

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During interview 8/31/17, at approximately 3:00 p.m. NA-C after R73's stroke she seems more sad. NA-C stated that prior to the stroke R73 dressed and groomed herself with occasional assist to tuck in a blouse. NA-C stated since the stroke, R73 needs total assistance with all her daily needs.

During interview 8/31/17, at 3:16 p.m. FM-A stated the facility called her on 6/10/17, and left her a message. The facility did not call FM-B who was (R73's) secondary emergency contact.

Although R73 had a change in condition on 6/10/17, with stroke symptoms, the facility failed to provide prompt emergency treatment by not sending R73 immediately to the ED following R73's POLST, which outlined R73's wanted treatment for reversible conditions. The facility's failure to respond in a timely manner, prevented R73 from receiving tPA medication, which is time sensitive and must be administered within 3 hours to reverse stroke symptoms. As a result of not receiving this medication, R73 had a significant change in her ADL's and was dependent upon staff, resulting in actual harm to R73.

A facility policy Change In Condition reviewed 9/15/08, indicated, "Except in medical emergency or when a resident is incompetent, the facility must consult with the resident immediately and notify the residents's physician, and if known the resident's legal representative or interested family member when there is: a) A change in resident's physical, mental or psychosocial status. b) A need to alter treatment significantly. c) A decision to transfer or discharge the resident from the facility." The policy further indicated to notify the family significant other

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when there is a change in status of a resident, the "RN or designee will: 1. Notify the first designated contact person 2. If unable to locate this individual, the next designated individual will be contacted."

A facility policy Emergency Care undated indicated licensed nursing staff will provide care for residents in an emergency situation and the procedure would be to stay with the resident while 911 would be called, give address, nature of the problem and do not hang up until told to do so. And in a non-life threatening emergency to give emergency care, notify physician, if needed call for ambulance and notify family.

A facility policy St. Clare Living Community Of Mora Policy and Procedure For Documentation Guidelines And Maintaining Legally Sound Health Record dated 1/2017, indicated under notification or communication that notification to the resident's physician, nurse practitioner or family is required. When a discussion with the resident's family occurs regarding care of the resident, all such communication (including attempts at notification) have to be charted. Include the time and method of all communications. The entry has to include any orders received or responses, the implementation of such orders if any and the resident's response. Messages left on answering machines should be limited to a request to return call and does not meet the definition of notification. Make sure to report to the the next shift that a message was left with the family and that they need to follow up with another call.

A facility policy St. Clare Living Community dated 3/8/11, indicated under "Policy: Each resident will have a completed POLST form included in their medical record. This form will be completed

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21810	Continued From page 25 based on wishes of the resident and/or appointed representative agent. The form will be revived regularly and kept current. Purpose: To provide the nursing staff, physicians, family and all others involved with the care of the resident, a written plan that states the resident's wishes about how they want to manage their treatment and care. This form will address their wishes not only related to the end of life, but also the quality of life they desire while living with a chronic illness." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding implementation of Physician Orders for Life Sustaining Treatment (POLST), inservice staff to ensure adequate and appropriate knowledge and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21810		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area	21880		10/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00814	A. BUILDING: ______ B. WING ______	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21880	Continued From page 26 nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to resolve concerns from residents and families regarding flies in the facility. This practice had the potential to affect all 56 residents in the facility. Findings include:	21880	Correction Completed	

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21880	Continued From page 27	21880		

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 [the 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.

During interview on 8/29/17, at 12:28 p.m. R82 stated there were numerous flies hanging around and noticed them mainly in the dining room.

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21880	Continued From page 28	21880		

On 8/31/17, a 1:12 p.m. the certified dietary manager (CDM) stated the flies had become a problem in the dining room again about a week or two ago and stated the administrator was aware of the problem. The CDM further stated FM-A had voiced complaints about the flies.

When interviewed on 8/31/17, at 1:13 p.m. the wellness director (WD) stated the residents mentioned flies at the resident council meeting in July. WD stated following the resident council meeting, WD brought the resident concern to the the administrator. WD stated at the August resident council meeting residents had no complaints regarding the flies. However, WD did not ask the residents specifically about fly concerns and the residents were not given a response to the previous months concern about flies.

During interview on 8/31/17, at 1:22 p.m. the administrator stated the flies were coming in through the french doors in the dining room, as the doors were open, to allow residents to attend activities in the courtyard. The administrator stated he was aware of the resident council members complaint about the flies, as well as FM-A's complaints. The administrator stated the facility placed fly lights through out the facility and moved the facility dumpster last year in an effort to reduce the flies. The administrator stated he had not addressed resident and family concerns about the flies this year as he wasn't sure how to correct the issue. The administrator further stated he had not contacted the facility's pest control contractor this year regarding the flies.

On 8/31/17, at 3:48 p.m. FM-A stated the administrator had never verbally or in writing

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21880	Continued From page 29 addressed his fly concern in the faciilty. 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.	21880		