Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2023

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

RE: CCN: 245291
Cycle Start Date: March 16, 2023

Dear Administrator:

On March 16, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 16, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 16, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 16, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by May 16, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Clare Living Community Of Mora will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 16, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 16, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

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 _____	C 03/16/2023

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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E 000	Initial Comments On 3/13/2023 through 3/16/2023, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/13/2023 through 3/16/2023, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H52919168C(MN90576) and H52919185C (MN85217). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/2023

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 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential	F 609	It is the policy of St. Clare Living Community of Mora to ensure that all	5/2/23

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F 609	Continued From page 2 abuse was reported to the State agency (SA) in a timely manner for 1 of 1 residents (R15) reviewed who reported an allegation during the survey. Findings include: R15's Annual Minimum Data Set (MDS) dated 12/30/22, identified R32 had no delusional or hallucination-related behaviors during the review period, and R15 usually understand others. R15's MDS also noted need for extensive physical assistance from one staff for transfers, bed mobility, and toileting. Diagnosis identified dementia, (a brain disease affecting memory and function). R15's care plan last reviewed 1/5/23, identified impaired communication related to dementia, with interventions including qualified nursing staff to monitor me for changes, and to speak directly to R15. Care plan also identified problems with mobility and required assistance to reposition and transfer. During an interview on 3/13/23 at 5:39 p.m. R15 stated she felt that she had been abused. She alleged a man nurse aide came in at night and yelled in her ear. Further, there were two "bigger girls" that had been rough with her. R15 could not recall if she had told anyone, or date and time the events had occurred. On 3/13/23 at 6:14 p.m. the surveyor immediately reported the allegation of potential abuse to the facility administrator. On 3/14/23 at 1:24 p.m. Director of Nursing (DON), said she went in to visit R15 last night after she was made aware of the potential abuse	F 609	alleged violations involving abuse, neglect, exploitation, or mistreatment and misappropriation of property are reported immediately, but not later than 2 hours after the allegation is made. St. Clare Living Community failed to follow facility policy to ensure allegation of potential abuse was reported to the MDH in a timely manner. R15 was initially interviewed on the evening of 3/13/23 by Director of Nursing regarding report of being “handled roughly” and a man “yelling in her ear”. On 3/14/23 resident and POA were interviewed regarding allegations of potential abuse and staff interviews were also conducted on this day. State Operations Manual definition of abuse was reviewed on 3/15/23 and a report was made to the MDH Incident Reporting for Providers website. St. Clare Living Community Abuse Prevention Policy was reviewed on 3/15/23. Licensed nursing staff and direct care staff reeducated on facility Abuse Prevention Policy with emphasis on timely reporting criteria for immediate, not later than 2 hours, or not later than 24 hours on 4/19/23. Abuse prevention education will continue to be provided to all new employees, through orientation and annual training programs. These programs include but are not limited to formal in-service presented by licensed staff, online education, and review of policies and procedures. Abuse prevention audits will be completed through review of facility accident/incident reports, and review of resident progress notes to ensure allegations of abuse,	

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F 609	Continued From page 3 concern. The DON said her findings from speaking with R15, was that a couple of girl staff had been rough with her, and that a man had spoken loudly in her ear, but that R15 wasn't sure if the individuals were from the facility and could not identify any staff. R15 said she felt safe in the facility. The DON said she was still in the investigation process. On 3/15/23 at 11:02 a.m. DON said she had visited with resident and family again yesterday [3/14/23] and had revised R15's care plan to included only certain female caregivers. Further, DON stated they had potently narrowed down the male staff and would speak with him. The DON acknowledged R15 had used the words being handled roughly in her original interview on 3/13/23. DON stated the facility had not reported the abuse allegation at the time, because the interview "lacked time frames", "included random descriptions", and "unrelated events". Further, it was facility policy to investigate and report within 24 hours when abuse had occurred. On 3/15/23 at 12:56 p.m. DON stated she reviewed the State Operations Manual (SOM), reported the allegation to the state agency and acknowledged it was reported late. A provided Abuse Prevention Policy, dated 2/2023, identified a standard to prohibit mistreatment, neglect, and abuse of all residents, exploitation, and misappropriation of property. The policy continued, abuse means the willful infliction of injury, unreadable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. The policy stated The administrator, director of nursing, or designee will contact the Minnesota Department of Health	F 609	neglect, maltreatment, exploitation, and misappropriation of property are reported per facility policies and per CMS guidelines. These audits will be conducted three times a week for four weeks, three times bi-weekly for four weeks, monthly for three months and randomly thereafter. Results of these audits will be reported to the QA/QI Committee for review and further recommendation. Further system revisions and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance.	

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F 609	Continued From page 4 incident reporting or the Minnesota Adult Abuse Reporting Center (MAARC) no less than immediately and no greater than two hours.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing assistant (NA) staff correctly secured the lift buckle behind the legs to the mechanical sit to stand lift to ensure safe transfers for 1 of 5 residents. Findings included: R15's face sheet included diagnosis of dementia, (a brain disease affecting memory and function) generalized muscle weakness, hemiplegia and hemiparesis of a cerebral infarction related to right side dominant side (brain attack with functional reduction to the right side of the body), and a history of falls. R15's annual Minimum Data Set (MDS) dated 12/30/22, indicated R15 required extensive physical assistance from one staff for transfers, bed mobility, and toileting.	F 689	It is the policy of St. Clare Living Community of Mora to ensure that the residents environment as free of accident hazards as is possible, and each resident receives adequate supervision and assistant devices to prevent accidents. St. Clare Living Community failed to follow Transfer and Lifting policy specifically when using sit to stand mechanical lift for transfers. Facility staff failed to use calf strap for added stability for resident R15. Transfer and Lift policy reviewed 3/16/23. Licensed nursing staff and direct care staff reeducated on Transfer and lift policy with emphasis on proper sit to stand mechanical lift transfers on 3/19/23. Transfer and mechanical lift education will continue to be provided to all new employees, through orientation and annual training programs. These programs include but are not limited to formal in-service presented by licensed	5/2/23

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F 689	Continued From page 5 R15's care plan related to mobility and last reviewed on 1/5/23 stated a goal to continue transferring using the EZ stand lift (mechanical sit to stand lift) with an assist of 1 for transfer. Staff transfer and activity sheet received 3/16/23 for residents on west hall identified R15 transfers and toilets with 1 assist mechanical sit to stand lift. During observation on 3/15/23, at 7:40 a.m. nursing assistant (NA-B) transferred R15 from toilet to recliner in room with a mechanical sit to stand lift after completing toileting and morning cares, without securing the belt behind the lower legs of R15. On 3/15/23 at 7:45 a.m. NA-B stated the belted needed to be placed behind R15's legs when using the EZ stand lift and it was not. On 3/16/23 at 11:42 a.m. Registered Nurse (RN-C) stated her expectation was staff properly secured the straps around the waist and behind the back of the lower legs when transferring a resident with a mechanical sit to stand lift. On 3/16/23 at 11:55 a.m. Director of Nursing (DON) said the policy was that staff used the leg strap for added support when transferring. The DON continued that if staff did not properly secure the strap behind the legs, R15's foot could slip off the base of the lift stand resulting in a potential fall. Facility Transfer/Lifting Policy & Procedure dated 12/22, identified the purpose was to provide transfer techniques to reduce incidents of injuries to all residents and staff. Under section 5 of policy	F 689	staff, online education, and review of policies and procedures. Transfer and mechanical lift audits will be conducted three times a week for four weeks, three times bi-weekly for four weeks, monthly for three months and randomly thereafter. Results of these audits will be reported to the QA/QI Committee for review and further recommendation. Further system revisions and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance.	

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F 689	Continued From page 6 reviewing sit to stand lifts, step F said, for added stability, fasten strap around calves.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		5/2/23

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F 880	Continued From page 7 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure infection control practices were being followed for handwashing after providing care and cleansing equipment after use for 1 of 1 residents (R23) reviewed for infection control.	F 880	It is the policy of St. Clare Living Community of Mora to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable disease	

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	245291	A. BUILDING _____ B. WING _____	C 03/16/2023

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 880	Continued From page 8 Findings include: R23's face sheet undated, indicated R23 had diagnosis of Parkinson disease. R23's lab work dated 2/27/23, indicated positive enterocolitis due to clostridium difficile (bacterium that causes diarrhea and colitis (an inflammation of the colon)). R23's physician orders dated 2/16/23, indicated R23 was prescribed and administered Vancomycin (to treat and prevent various bacterial infections) 125 milligram (mg) orally four times a day for 17 days, and Cephalexin (used to treat infections) 500 mg three times a day. The east group sheet dated 3/16/23, indicated there were three residents that required a mechanical standing lift for assistance. During an interview on 3/14/23, at 8:20 a.m. trained medical assistant (TMA)-A stated we use the purple top wipes to clean the lift that went in and out of R23's room. TMA-A state we keep them in the isolation cart outside R23's room and in the drawer so other residents do not use them. During an observation on 3/14/23, at 12:53 p.m. dietary aid (DA)-A went into R23's room with no personal protective equipment (PPE) on and took off the lid, poured R23 water out of a pitcher, sat the pitcher of water down on the table, replaced the water cup lid and left R23's room. DA-A stated the licensed staff told her when she did not come in contact with R23 then she did not need to put on PPE when entering the room. DA-A pushed the food cart down the hall to pass beverages and snacks to other residents. DA-A did not perform hand hygiene with soap and water or hand sanitizer.	F 880	and infections. St. Clare Living Community failed to ensure infection control practices were being followed for hand washing and equipment cleaning per facility policy. Facility hand hygiene and equipment cleaning policies were reviewed/revised on 4/12/23. On 4/13/23 Administrator, DON, QMC, and Infection Preventionist (IDT) met and conducted RCA/Fishbone for hand hygiene and lift cleaning policy compliance. All staff will have assigned and completed hand hygiene training through an online program, Health Care Academy, to be completed by 5/2/23. All nursing staff meetings conducted on 4/19/23 to further educate on the importance of hand hygiene, and resident lift cleaning. On the spot training in hand hygiene will be performed as necessary to ensure compliance, as well as staff self-assessment for hand hygiene, and staff in-services to be conducted thereafter to review the importance of infection control specific to include hand hygiene. All employees upon hire are trained and complete hand washing competency. Hand hygiene and lift cleaning audits will be completed by IP or designee. Hand hygiene audits will be conducted four times per week, on rotating shifts, then will be conducted biweekly once compliance is achieved. Proper cleaning and disinfection of lifts will be audited on all shifts every day for one week. Once compliance is met, audits will then be conducted four times per week on rotating shifts, then will be conducted bi-weekly once compliance is achieved.	

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F 880	Continued From page 9 During an observation on 3/14/23 at 1:00 p.m. licensed practical nurse (LPN)-A brought a mechanical stand lift into R23's room. A sign on R23's door indicated contact precautions (everyone coming into a resident's room was asked to wear a gown, gloves, and mask) and to see the nurse before entering room. Another sign on the door indicated staff should wear a gown, gloves, and face mask when entering R23's room. LPN-A and LPN-B put on gown, mask, and gloves before entering R23's room. LPN-A brought the mechanical stand lift number three into R23's room. They performed peri cares for R23. LPN-A wiped the mechanical stand lift with a super sani wipe germicidal disposable wipe, a purple top container. The super sani wipe germicidal disposable wipe was in a holder on the mechanical stand lift. The super sani wipe germicidal disposable wipe was effective for bacteria, multi-drug resistant bacteria (term to refer to an isolate that is resistant to at least one antibiotic in three or more drug classes), viruses, bloodborne pathogens, tuberculosis (a disease caused by germs that are spread from person to person through the air), and pathogenic fungi (fungi that cause disease in humans). LPN-A removed PPE and used hand sanitizer. LPN-A brought the mechanical stand lift number three out of R23's room and placed the mechanical standing lift in an alcove in the hallway with other lifts. During constant observation of the mechanical lift from 1:00 p.m. to 3:08 p.m. -At 2:05 p.m. nursing assistant (NA)-C moved mechanical standing lift out of the alcove to obtain a full body lift and put the mechanical	F 880	Hand hygiene and cleaning/disinfection of lift audits will be reviewed/monitored by IDT monthly and QAPI quarterly until compliance is met. Once 100% compliance is achieved the facility will continue to conduct these audits randomly thereafter. Lift cleaning policy will be acknowledged and signed/reviewed by all direct care staff, and an online Health Care Academy course will be completed by 5/2/23. Staff will be trained in competency specific for proper use and sanitizing of lifts. A staff member will be assigned to deep clean lifts as indicated in the job description. Further system revisions and staff education will be provided if indicated by the audits. The Director of Nursing, Infection Preventionist, or designee is responsible for compliance. The facility will continue to provide ongoing education of hand hygiene, and resident lift cleaning policies for new employees and current employees as new guidance and policy updates become available. This education will be present via life all staff in-services, policy review/updates in written form, and facility online education program Health Care Academy.	

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F 880	Continued From page 10 standing lift number three back in the hallway alcove. -At 2:38 p.m. NA-D took the full body mechanical lift and mechanical standing lift out of the alcove to get another lift and placed the full body mechanical lift and mechanical standing lift back in the alcove. NA-D went to another resident's room. -At 2:57 p.m. NA-E took the mechanical standing lift number three into R135's room. NA-E used the mechanical standing lift number three to get R135 out of the wheelchair and into the bathroom. NA-E needed to replace the battery and at 3:00 p.m. left the room to get another battery. NA-E washed hands with soap and water and NA-E completed cares. NA-E brought R135 back to the wheelchair and sat R135 down. NA-E did not wipe the mechanical standing lift number three down with any disinfectant wipe and brought the mechanical standing lift number three to R23's room for staff to use. -At 3:08 p.m. NA-E stated lifts did not need to be wiped down unless they were on precautions. Staff wipe the lifts down with the purple top wipes. An interview on 3/15/23, at 7:10 a.m. LPN-A stated staff used the purple wipes on lifts. An interview on 3/15/23, at 7:35 a.m. NA-D stated mechanical standing lifts were wiped down after every use. NA-D stated the total body mechanical lift was wiped down only when the resident was on precautions. NA-D stated they used the purple top wipes for all the lifts and did not use the orange top wipe at all. On 3/15/23, at 12:59 p.m. registered nurse (RN)-A stated with clostridium difficile (c-diff) staff needed to use the orange top sani wipes	F 880		

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F 880	Continued From page 11 (disposable bleach wipes used for c difficile spores), they were bleach wipes. RN-A stated the purple top sani wipes did not cover the c-diff spores. RN-A stated she checked the isolation cart and made sure the signage was correct for the resident. RN-A stated staff were educated on using the orange top wipes for c-diff spores and to wash their hands with soap and water when finished in rooms with c-diff spores. RN-A stated c-diff spores live quit a while and staff could spread c-diff to others if they only used hand sanitizer. RN-A stated staff could spread c-diff if the lifts were not cleaned with the right product, the bleach wipes. RN-A stated all staff need to don PPE when entering a resident's room with c-diff. The facility policy Guidelines for Clostridium difficile with review date 2/2023, indicated all residents suspected of having c-diff, or another diarrheal illness, will be placed on contact precautions. -Gloves and gowns will be worn prior to entering the room and removed prior to exiting the room. -Perform hand hygiene before putting on gloves, after removing gloves, and anytime hands are visibly soiled. Soap and water are preferred, as alcohol-based hand sanitizers do not have an effect on c-diff. -Single-use, dedicated, or disposable equipment-such as blood pressure cuffs, stethoscopes, and thermometers will be used. If single-use, dedicated, or disposable equipment is not available, shared equipment must be cleaned and disinfected immediately after use and between residents. The facility policy Contract Precautions dated 2/2023, indicated for cleaning a room with c-diff	F 880		

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F 880	Continued From page 12 present, using a disinfectant with a 1:10 dilution of bleach solution is recommended, unless the facility has a specific disinfectant that will kill c-diff.	F 880		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes	F 887		5/2/23

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F 887	Continued From page 13 documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures to ensure each resident or resident's representative received education regarding the benefits and potential side effects of the COVID-19 vaccination. In addition, the facility failed to ensure COVID-19 vaccinations were offered to 2 of 5 residents (R31, R201) reviewed for COVID-19 vaccination status. Findings include: R31's face sheet indicated admission on 2/27/23. R31's electronic medical record (EMR) lacked	F 887	St. Clare Living Community of Mora failed to develop policies and procedures to ensure resident's or resident representatives received education regarding COVID-19 vaccinations. Facility also failed to implement a process for follow up with non-vaccinated, and non-fully vaccinated residents or resident representative. Facility COVID-19 Health Care Staff Vaccine and Resident Testing policy was reviewed and revised on 4/5/23. Resident vaccination status is addressed on admission and education is provided. Facility has adopted a COVID	

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F 887	Continued From page 14 documentation of COVID-19 vaccination. R1's EMR also lacked evidence education regarding the benefits and potential side effects of COVID-19 vaccination was provided to R31 and/or R31's representative upon and/or after admission. R31's EMR lacked documentation of COVID-19 vaccine contraindications. R201's face sheet indicated R201 had admitted to the facility on 3/6/23. R201's electronic medical record (EMR) lacked documentation of COVID-19 vaccination. R201's EMR also lacked evidence education regarding the benefits and potential side effects of COVID-19 vaccination was provided to R201 and/or R201's representative upon and/or after admission. R201's EMR lacked documentation of COVID-19 vaccine contraindications. During interview on 3/15/23, at 12:59 p.m. Registered Nurse (RN)-A stated COVID-19 vaccinations were offered to residents shortly after admission. RN-A stated when a resident requested the COVID-19 vaccination, she helped set it up through county public health services. RN-A stated the facility did not have a policy or specific consent form with education on risks and benefits of COVID-19 vaccination. RN-A stated normally she documented the conversation regarding the COVID-19 vaccinations in a resident progress note in their EMR. RN-A stated education and offer of the COVID-19 vaccination had not been done with R1 or R201 and/or their representatives upon or after admission to the facility. When interviewed on 3/16/23 at 9:34 a.m. the director of nursing (DON) stated the facility had no facility policy regarding COVID-19 vaccination	F 887	Vaccine & Education form for non-vaccinated or non-fully vaccinated residents or resident representatives will accept or decline the next or first eligible dose of the vaccine. Should the resident indicate that they would like the vaccine, the facility will set up arrangements for the resident to receive the vaccine. Resident COVID vaccines will be re-addressed annually and as requested. R31 received COVID vaccine education and signed declination on 4/13/23, all other like residents who are not fully vaccinated have received COVID vaccine education and have signed to accept or decline. Licensed nursing staff educated on facility policy and process on 4/5/23. COVID vaccine and education audits will be conducted three times a week for four weeks, three times bi-weekly for four weeks, monthly for three months and randomly thereafter. Results of these audits will be reported to the QA/QI Committee for review and further recommendation. Further system revisions and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance.	

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F 887	Continued From page 15 for residents.	F 887		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 10, 2023

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

Re: Event ID: WJ7L11

Dear Administrator:

The above facility survey was completed on March 16, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/13/23 through 3/16/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be IN compliance with MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H52919168C (MN90576) and H52919185C (MN85217). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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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	245291	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2023**

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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) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/16/2023. At the time of this survey, St. Clare Living Community of Mora was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 04/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2023**

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

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K 000	Continued From page 2 construction opened to the west in 2005. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/16/2023 at 12:00 PM, it was revealed by a	K 345	It is the policy of St. Clare Living Community of Mora to provide a safe environment for all residents and staff. St. Clare Living Community failed to conduct the semi-annual fire alarm testing and documentation. On 3/16/23 Ahern Fire Protection Company completed facility semi-annual fire alarm testing inspection with no concerns in the system. Ahern Fire Protection has added facility to system for semi-annual inspection. The Environmental Service Director will	3/16/23

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K 345	Continued From page 3 review of available documentation that the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	continue to ensure semi-annual alarm testing and documentation is completed per fire safety codes. The Environmental Director or designee is responsible for compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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 _____ 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 REQUIREMENT is not met as evidenced by: Based on a observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, 5.3.2.1,	K 353	It is the policy of St. Clare Living Community of Mora to provide a safe environment for all residents and staff. St. Clare Living Community failed to conduct the semi-annual fire alarm testing and documentation. On 3/16/23 Ahern Fire Protection Company completed facility	3/23/23

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K 353	Continued From page 4 5.4.1.4 and 5.4.1.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/16/2023 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that neither the annual fire sprinkler test documentation or tag on the main sprinkler riser could not be located at the time of the survey. 2. On 03/16/2023 between 09:00 AM and 12:00 PM, it was revealed by observation that there were 4 unsecured fire sprinkler heads that were not protected from being damaged, stored loosely within the spare sprinkler head boxes at the main sprinkler riser. An interview with the Maintenance Director verified these deficient finding at the time of discovery.	K 353	semi-annual fire alarm testing inspection with no concerns in the system. Ahern Fire Protection has added facility to system for semi-annual inspection. The Environmental Service Director will continue to ensure semi-annual alarm testing and documentation is completed per fire safety codes. The Environmental Director or designee is responsible for compliance. It is the policy of St. Clare Living Community of Mora to ensure fire sprinkler heads are protected from being damaged and stored per life safety code. On 3/16/23 a new sprinkler head box was ordered. On 3/23/23 the sprinkle head box was installed. All sprinkler heads are now secured, protected from being damaged, and are no longer stored loosely in the sprinkler head box per life safety code. The Environmental Service Director or designee is responsible for compliance.	