



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 31, 2024

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

RE: CCN: 245291
Cycle Start Date: April 12, 2024

Dear Administrator:

On May 22, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 31, 2024

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

Re: Reinspection Results
Event ID: TSRR12

Dear Administrator:

On May 22, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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April 24, 2024

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

RE: CCN: 245291
Cycle Start Date: April 12, 2024

Dear Administrator:

On April 12, 2024, a survey was completed at your facility by the Minnesota Department of Health, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

St Clare Living Community of Mora

April 24, 2024

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the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 12, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by October 12, 2024 (six months after the identification of noncompliance), your provider agreement will be terminated. 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.

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.

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/lrc_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.

St Clare Living Community of Mora

April 24, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "H. Zahler". The signature is written in a cursive, flowing style.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/12/2024
NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA			STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051		
(X4) ID PREFIX TAG	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	<p>INITIAL COMMENTS</p> <p>On 4/11/24 through 4/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed:</p> <p>H52912902C (MN00102278);</p> <p>H52913005C (MN00101782);</p> <p>H52913009C (MN00099589) with a deficiency issued at F689.</p> <p>In addition, as a result of the investigation a deficiency was cited at F684.</p> <p>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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000			
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p>	F 684		5/13/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/02/2024

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 684	<p>Continued From page 1</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to manage bowel and constipation needs for 1 of 3 residents (R2) who were reviewed.</p> <p>Findings include:</p> <p>R2's significant change Minimal Data Set (MDS) dated 1/25/24, revealed R2 had diagnoses which included Alzheimer's Disease, constipation and had severely impaired cognition. Further, MDS assessment indicated R2 was incontinent of bowel.</p> <p>R2's care plan revised 12/16/23, indicated R2 was at risk for incontinence due to diagnoses of Alzheimer's disease, dementia, constipation and previous right and left femur fractures with repair. R2's goal was identified as have a large bowel movement (BM) at least every three days and interventions included: qualified nursing staff will monitor BM status daily, administer medications as ordered, and indicated R2 required staff assistance for toileting needs.</p> <p>R2's Bowel Assessment dated 1/23/24, revealed R2 was occasionally incontinent of bowel and did not feel urge sensation for BM.</p>	F 684	<p>It is the policy of St. Clare Living Community of Mora to manage bowel and constipation needs for all residents. Bowel Protocol reviewed and revised on 4/18/24. For resident R2 care plan reviewed and revised on 4/19/24 & 5/2/24. For all other like residents who were identified by review of diagnoses related to constipation, care plans and bowel observations were reviewed and revised as appropriate. Nursing staff educated on facility Bowel Protocol on 4/20/24. Nursing department meeting to be held on 5/8/24, and 5/9/24 to include detailed information regarding bowel management, documentation, standing orders, and MD/NP as needed prescribed orders for bowel management. Resident bowel management education will continue to be provided to all new nursing employees through orientation and as needed. These programs include but are not limited to formal in-service presented by licensed staff, online education programs (Health Care Academy), and review of policies and procedures. For residents affected by this practice, a bowel management audit will be conducted 2 times per week for 30 days, weekly for 30 days, monthly for 3</p>	

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F 684	<p>Continued From page 2</p> <p>Review of R2's output for BM revealed the following: -From 12/29/23 through 1/4/24, no BM was documented. -From 2/4/24 through 2/9/24, no BM was documented. -From 2/14/24 through 2/17/24, no BM was documented. -From 2/23/24 through 2/28/24, no BM was documented.</p> <p>R2's medical record lacked evidence of facility's Bowel Protocol being implemented during above time frames documented with out a BM.</p> <p>On 4/11/24 at 1:35 p.m., licensed practical nurse (LPN)-A stated R2 was incontinent of bowel and bladder "most of the time" and had issues with constipation "at times" and staff administer Milk of Magnesia (MOM) or MiraLAX which was effective. Further, LPN-A stated the facility had a Bowel Movement Protocol staff are expected to follow and then document in the resident's medical record.</p> <p>On 4/11/24 at 2:00 p.m., registered nurse (RN)-A stated she was not aware of any constipation issues for R2. Further, RN-A stated staff were expected to follow the facility's Bowel Movement Protocol and document a progress note in the resident's medical record.</p> <p>On 4/11/24 at 3:51 p.m., RN-B stated R2 had impaired cognition and required staff assistance for toileting due to incontinence, however RN-B stated she was not aware of any constipation concerns for R2.</p> <p>On 4/12/24 at 11:20 a.m., director of nursing</p>	F 684	<p>months, and randomly thereafter with results reported to the QA/QI Committee for review and further recommendation. 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.</p>	

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F 684	<p>Continued From page 3</p> <p>(DON) indicated R2 had severe cognitive impairment and required staff assistance with toileting due to incontinent of bowel and bladder. DON stated R2 did have concerns with constipation and required PRN (as needed) medications for relief. Further, DON confirmed R2's medical record lacked evidence of a recorded BM for the following dates: 12/29/23 through 1/4/24; 2/4/24 through 2/10/24; 2/14/24 through 2/17/24; and 2/23/24 through 2/28/24. DON stated R2's medical record also lacked evidence of the facility's Bowel Movement Protocol being implemented for those dates as well. In addition, DON stated staff were expected to follow the facility's BM protocol.</p> <p>Review of facility document titled Bowel Protocol dated 5/17, directed staff to print and review bowel report daily after 4:00 a.m. and the day nurse would review for any urgent bowel concerns and offer prune juice. Further, protocol directed staff on day two with no bowel movement evening shift would administer Milk of Magnesia, day three with no bowel movement results staff would administer a Bisacodyl suppository, day four with no bowel movement results administer a fleet enema. In addition, the protocol directed staff if no bowel movement results on day three the day shift nurse would be expected to call the provider for further orders and request routine or change in medication.</p>	F 684		
F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p>	F 689		5/13/24

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F 689	<p>Continued From page 4</p> <p>§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 interview and document review, the facility failed assess and implement new intervention(s) to prevent future falls for 1 of 3 residents (R2) reviewed for accidents.</p> <p>Findings include:</p> <p>R2's significant change Minimal Data Set (MDS) dated 1/25/24, revealed R2 had diagnoses which included Alzheimer's Disease, constipation and had severely impaired cognition. Further, MDS assessment indicated R2 had two or more falls with no injuries since last assessment.</p> <p>R2's care plan revised 2/28/24, identified R2 was at risk for falls related to diagnoses and medications which may increase the risk for falls. R2's care plan revealed the following interventions to reduce the occurrence and injuries with falls: therapy assessment, encourage resident to wear gripper slippers at night, toileting between 3:30 a.m. and 4:00 a.m., encourage and participate in activities, ambulate with staff daily, bolstered mattress on bed, padded call light within reach and position to help alert staff when attempting to get up from bed.</p> <p>R2's Fall Risk assessment dated 1/23/24, identified R2 had intermittent confusion, poor recall, judgment, and safety awareness and was determined to be at risk for falls.</p> <p>R2's Safety Events-Fall report dated 2/12/24,</p>	F 689	<p>It is the policy of St. Clare Living Community of Mora to provide an environment as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. Falls and Fall Risk Managing policy reviewed on 4/19/24 and remains up to date. For resident R2 care plan, and nursing assistant assignment sheet reviewed and revised on 5/2/24 to include all fall interventions and toileting that relates to resident fall history. Nursing staff reeducated on facility Falls and Fall Managing policy on 4/20/24. Nursing department meeting to be held on 5/8/24, and 5/9/24 to include high fall risk residents and fall interventions. For all other like residents who were identified by review of facility falls in the past 90 days, and resident fall risk scores. Care plans and nursing assistant assignment sheets were updated to reflect current and appropriate fall interventions. Resident fall education will continue to be provided to all new nursing employees through orientation, annual training and as needed. These programs include but are not limited to formal in-service presented by licensed staff, online education programs (Health Care Academy), and review of policies and procedures. For residents affected by this practice, an</p>	

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F 689	<p>Continued From page 5</p> <p>revealed R2 had an unwitnessed fall in her room at 8:15 p.m. R2 was noted to be attempting to self-transfer from bed to her wheelchair and did not sustain an injury. Further, report indicated R2 was impulsive with poor safety awareness. Interdisciplinary team (IDT) reviewed and ruled out abuse and neglect, and "refer to fall CP [care plan] for interventions". However, R2 medical record lacked evidence a new intervention was implemented to prevent re-occurrence.</p> <p>R2's Safety Events-Fall report dated 2/25/24, revealed R2 had an unwitnessed fall in her room at 8:16 p.m. R2 was self-transferring, without shoes or gripper socks, and fell. R2 did not sustain an injury. Further, report indicated R2 was impulsive with poor safety awareness and does not remember to use call light or that she requires assistance with mobility. IDT was noted to review the fall. However, R2 medical record lacked evidence a new intervention was implemented to prevent re-occurrence.</p> <p>On 4/11/24 at 12:24 p.m., R2 was observed in her room sitting in her wheelchair. R2 appeared to be positioned well in wheelchair, shoes on, bed was appropriate height and had a concave mattress, room was free of clutter, and gray padded call light was within reach. R2 denied having any falls while living in the facility and stated if she needed staff, she would use the call light.</p> <p>On 4/11/24 at 2:00 p.m., registered nurse (RN)-A stated R2 was at risk for falls and staff were directed to visually check on her frequently, bed in lowest position when in bed, walking program, and R2 was enrolled with hospice. Further, RN-A stated R2 had not had a fall for two months.</p>	F 689	<p>audit on resident falls, and interventions will be conducted 2 times per week for 30 days, weekly for 30 days, monthly for 3 months, and randomly thereafter with results reported to the QA/QI Committee for review and further recommendation. 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.</p>	

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F 689	<p>Continued From page 6</p> <p>On 4/11/24 at 2:44 p.m., nursing assistant (NA)-A stated R2 was identified as a fall risk due to R2 self-transferring without staff assistance. Further, NA-A stated staff were directed to keep bed in low position when R2 was in bed, padded call light placed next to her to alert staff when R2 was moving, gripper socks when in bed or shoes on when in wheelchair, wheelchair next to bed in case R2 attempts to self transfer out of bed, and visually checking R2 frequently.</p> <p>On 4/11/24 at 3:51 p.m., RN-B stated the IDT will meet and review each fall that occurs and determine a root cause for the fall and any further interventions needed. Further, RN-B stated the root cause analysis and new interventions are documented in the incident report (Safety Event-Fall) and the new interventions would be verbally communicated to staff as well as updating the resident's care plan. RN-B stated R2 was identified to be at risk for falls and interventions include frequent visual checks, toileting plan, gripper socks at bedtime, concave mattress, and a gray padded call light. In addition, RN-B confirmed R2 had fallen on 2/12/24 and 2/25/24, and there were no new interventions implemented following either fall to prevent reoccurrence. RN-B stated these two falls both occurred closer to the time when R2 likes to go to bed, and the IDT will try to identify a trend or pattern with falls and implement an intervention to hopefully decrease the fall but "we did not do that here it appears".</p> <p>On 4/12/24 at 11:20 a.m., director of nursing (DON) indicated each morning the IDT would review any incidents that occurred. DON stated the nurse manager would be expected to gather more information related to the fall and the IDT</p>	F 689		

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(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 689	Continued From page 7 would discuss the fall and determine a root cause for each fall and develop an intervention. Review of facility policy titled Falls and Fall Risk Managing revised 9/23, revealed if falling reoccurs despite initial interventions, staff would implement additional or different interventions, or if underlying causes cannot be identified still would try various interventions based on the assessment of the nature or category of falling was reduced or stopped. Further, policy indicated if the resident continues to fall, staff would re-evaluate the situation and whether it was appropriate to continue or change current interventions.	F 689		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: TSRR11

Dear Administrator:

The above facility was surveyed on April 11, 2024 through April 12, 2024, 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

St Clare Living Community of Mora

April 24, 2024

Page 2

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.

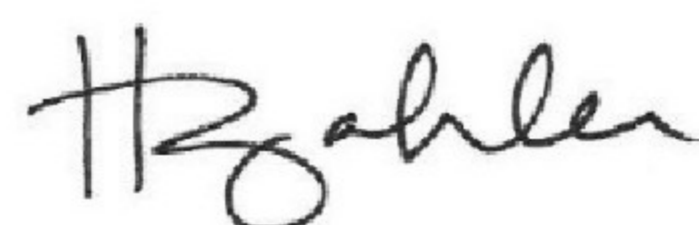
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00814	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2024
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NAME OF PROVIDER OR SUPPLIER ST CLARE LIVING COMMUNITY OF MORA	STREET ADDRESS, CITY, STATE, ZIP CODE 110 NORTH 7TH STREET MORA, MN 55051
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 4/11/24 through 4/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/02/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00814	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2024
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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed:</p> <p>H52912902C (MN00102278);</p> <p>H52913005C (MN00101782);</p> <p>H52913009C (MN00099589) with a licensing order issued at (0830).</p> <p>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.</p> <p>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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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</p>	2 000		
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2 000	Continued From page 2 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. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed assess and implement new intervention(s) to prevent future falls for 1 of 3 residents (R2) reviewed for accidents.	2 830	It is the policy of St. Clare Living Community of Mora to provide an environment as free of accident hazards as is possible, and each resident receives	5/13/24

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2 830	<p>Continued From page 3</p> <p>Findings include:</p> <p>R2's significant change Minimal Data Set (MDS) dated 1/25/24, revealed R2 had diagnoses which included Alzheimer's Disease, constipation and had severely impaired cognition. Further, MDS assessment indicated R2 had two or more falls with no injuries since last assessment.</p> <p>R2's care plan revised 2/28/24, identified R2 was at risk for falls related to diagnoses and medications which may increase the risk for falls. R2's care plan revealed the following interventions to reduce the occurrence and injuries with falls: therapy assessment, encourage resident to wear gripper slippers at night, toileting between 3:30 a.m. and 4:00 a.m., encourage and participate in activities, ambulate with staff daily, bolstered mattress on bed, padded call light within reach and position to help alert staff when attempting to get up from bed.</p> <p>R2's Fall Risk assessment dated 1/23/24, identified R2 had intermittent confusion, poor recall, judgment, and safety awareness and was determined to be at risk for falls.</p> <p>R2's Safety Events-Fall report dated 2/12/24, revealed R2 had an unwitnessed fall in her room at 8:15 p.m. R2 was noted to be attempting to self-transfer from bed to her wheelchair and did not sustain an injury. Further, report indicated R2 was impulsive with poor safety awareness. Interdisciplinary team (IDT) reviewed and ruled out abuse and neglect, and "refer to fall CP [care plan] for interventions". However, R2 medical record lacked evidence a new intervention was implemented to prevent re-occurrence.</p>	2 830	<p>adequate supervision and assistance devices to prevent accidents. Falls and Fall Risk Managing policy reviewed on 4/19/24 and remains up to date. For resident R2 care plan, and nursing assistant assignment sheet reviewed and revised on 5/2/24 to include all fall interventions and toileting that relates to resident fall history. Nursing staff reeducated on facility Falls and Fall Managing policy on 4/20/24. Nursing department meeting to be held on 5/8/24, and 5/9/24 to include high fall risk residents and fall interventions. For all other like residents who were identified by review of facility falls in the past 90 days, and resident fall risk scores. Care plans and nursing assistant assignment sheets were updated to reflect current and appropriate fall interventions. Resident fall education will continue to be provided to all new nursing employees through orientation, annual training and as needed. These programs include but are not limited to formal in-service presented by licensed staff, online education programs (Health Care Academy), and review of policies and procedures. For residents affected by this practice, an audit on resident falls, and interventions will be conducted 2 times per week for 30 days, weekly for 30 days, monthly for 3 months, and randomly thereafter with results reported to the QA/QI Committee for review and further recommendation. 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</p>	
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Minnesota Department of Health

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2 830	<p>Continued From page 4</p> <p>R2's Safety Events-Fall report dated 2/25/24, revealed R2 had an unwitnessed fall in her room at 8:16 p.m. R2 was self-transferring, without shoes or gripper socks, and fell. R2 did not sustain an injury. Further, report indicated R2 was impulsive with poor safety awareness and does not remember to use call light or that she requires assistance with mobility. IDT was noted to review the fall. However, R2 medical record lacked evidence a new intervention was implemented to prevent re-occurrence.</p> <p>On 4/11/24 at 12:24 p.m., R2 was observed in her room sitting in her wheelchair. R2 appeared to be positioned well in wheelchair, shoes on, bed was appropriate height and had a concave mattress, room was free of clutter, and gray padded call light was within reach. R2 denied having any falls while living in the facility and stated if she needed staff, she would use the call light.</p> <p>On 4/11/24 at 2:00 p.m., registered nurse (RN)-A stated R2 was at risk for falls and staff were directed to visually check on her frequently, bed in lowest position when in bed, walking program, and R2 was enrolled with hospice. Further, RN-A stated R2 had not had a fall for two months.</p> <p>On 4/11/24 at 2:44 p.m., nursing assistant (NA)-A stated R2 was identified as a fall risk due to R2 self-transferring without staff assistance. Further, NA-A stated staff were directed to keep bed in low position when R2 was in bed, padded call light placed next to her to alert staff when R2 was moving, gripper socks when in bed or shoes on when in wheelchair, wheelchair next to bed in case R2 attempts to self transfer out of bed, and visually checking R2 frequently.</p> <p>On 4/11/24 at 3:51 p.m., RN-B stated the IDT will</p>	2 830	on-going compliance.	
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2 830	<p>Continued From page 5</p> <p>meet and review each fall that occurs and determine a root cause for the fall and any further interventions needed. Further, RN-B stated the root cause analysis and new interventions are documented in the incident report (Safety Event-Fall) and the new interventions would be verbally communicated to staff as well as updating the resident's care plan. RN-B stated R2 was identified to be at risk for falls and interventions include frequent visual checks, toileting plan, gripper socks at bedtime, concave mattress, and a gray padded call light. In addition, RN-B confirmed R2 had fallen on 2/12/24 and 2/25/24, and there were no new interventions implemented following either fall to prevent reoccurrence. RN-B stated these two falls both occurred closer to the time when R2 likes to go to bed, and the IDT will try to identify a trend or pattern with falls and implement an intervention to hopefully decrease the fall but "we did not do that here it appears".</p> <p>On 4/12/24 at 11:20 a.m., director of nursing (DON) indicated each morning the IDT would review any incidents that occurred. DON stated the nurse manager would be expected to gather more information related to the fall and the IDT would discuss the fall and determine a root cause for each fall and develop an intervention.</p> <p>Review of facility policy titled Falls and Fall Risk Managing revised 9/23, revealed if falling reoccurs despite initial interventions, staff would implement additional or different interventions, or if underlying causes cannot be identified still would try various interventions based on the assessment of the nature or category of falling was reduced or stopped. Further, policy indicated if the resident continues to fall, staff would re-evaluate the situation and whether it was</p>	2 830		
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2 830	<p>Continued From page 6</p> <p>appropriate to continue or change current interventions.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		
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