



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 5, 2023

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

RE: CCN: 245291
Cycle Start Date: July 27, 2023

Dear Administrator:

On August 15, 2023, we notified you a remedy was imposed. On October 3, 2023, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 2, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 30, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 15, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 2, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us



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October 5, 2023

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

Re: Reinspection Results
Event ID: UZIY12

Dear Administrator:

On October 3, 2023 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 July 27, 2023. 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 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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September 15, 2023

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

RE: CCN: 245291
Cycle Start Date: July 27, 2023

Dear Administrator:

On August 15, 2023, we informed you of imposed enforcement remedies.

On September 1, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 30, 2023, will remain in effect.

This Department continues to recommend that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 30, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 30, 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.

As we notified you in our letter of August 15, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

An equal opportunity employer.

St Clare Living Community of Mora

September 15, 2023

Page 2

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 30, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082

St Clare Living Community of Mora

September 15, 2023

Page 3

Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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 January 27, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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
202-795-7490

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/ 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 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

St Clare Living Community of Mora

September 15, 2023

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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.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is fluid and cursive, with the first letter of the first name being a large, stylized 'H'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 09/28/2023
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 09/01/2023
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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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(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
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F 000	<p>INITIAL COMMENTS</p> <p>On 8/31/23 to 9/1/23, 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. H52914984C (MN96233) with a deficiency issued at 689.</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 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> <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 observation, interview and document review the facility failed to follow fall interventions</p>	F 689	It is the policy of St. Clare Living Community of Mora to provide an	10/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/22/2023
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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 689	<p>Continued From page 1 for 1 of 3 residents (R1) reviewed for falls.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 8/10/23, identified R1 had moderately impaired cognition. R1 needed extensive assist of one for bed mobility, transfers, toileting, and walking in room and corridor. R17's balance required corrective assistance from staff with transfers and ambulation. R1 had no history falls since admission and diagnoses included hypoxemia and heart failure.</p> <p>The group sheet dated 8/23/23, utilized by nursing assistants, identified R1 was a high risk for falls does not identify use of transfer belt use.</p> <p>R1's care plan dated 8/25/23, identified a diagnosis of a T8 fracture following a recent fall and was a high risk for falls. On 8/18/23, following a 8/17/23, fall the care plan was updated to include staff to place gripper socks on at night; however, the care plan lacked direction for staff to utilize a transfer belt with all transfers and ambulation.</p> <p>On 8/31/23 at 1:00 p.m., R1 stated she had a recent fall in her room and was transferred by ambulance. Staff used the belt and it helped her transfers. R1 was still having a lot of pain when she moved, but when she was laying in bed the pain was best.</p> <p>On 8/31/23 at 2:25 p.m., trained medication aide (TMA)-A stated the group sheets told staff how to transfer residents and what care they needed. TMA-A explained when a resident was an assist of one, that meant staff needed to use a transfer</p>	F 689	<p>environment as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. For resident R1 care plan and nursing assistant group assignment sheets were reviewed and revised on 9/21/23 to reflect transfer belt use with all transfers and ambulation. For all other like residents who were identified by review of care plans and transfer status. Care plans and nursing assistant group assignments were updated to reflect transfer belt use for residents who are assist of one, stand by assist, and contact guard assist. Nursing Assistants and Licensed Nursing staff reeducated on facility Transfer/Lifting policy and procedure which included types of transfers, transfer belt use, and who to report resident transfer concerns too. Education completed with employees 9/5/23 through 9/22/23. Resident transfer and lifting education will continue to be provided to all new 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, a transfer audit will be conducted 3 times per week for 30 days, weekly for 30 days, monthly, for 3 months and randomly thereafter with results reported to QA/QI Committee for review and further recommendation. Further system revision and staff education will be provided if indicated by audits and/or recommended</p>	

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

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F 689	<p>Continued From page 2</p> <p>belt and stand by the resident when the resident transferred or walked somewhere.</p> <p>On 8/31/23 at 2:30 p.m., licensed practical nurse (LPN)-B stated group sheets were used so that everyone knew what cares to do and how to transfer each resident. An assist of one meant staff would use a transfer belt to physically assist the resident as needed along with whatever other devices the resident needed. Staff would also use a transfer belt for residents that required stand by assist.</p> <p>On 8/31/23 at 2:38 p.m., nursing assistant (NA)-A stated staff worked off the group sheets. When a resident needed stand by assistance, the resident did most of the work, but staff still needed to put a transfer belt on the resident in case the resident needed help. When a resident required an assist of one, staff should hold onto to the transfer belt because staff may need to help a resident regain or maintain their balance during a transfer.</p> <p>On 8/31/23 at 2:52 p.m., LPN-A stated we put transfer belts on residents that are stand by assist, so staff have something to grab to help the resident regain their balance. If a resident is an assist of one, staff should put a transfer belt on the resident and hold onto it. Staff hold on because an assist of one may need staff to use their own strength to help the resident maintain stability and posture or to correct a loss of balance.</p> <p>On 8/31/23 at 3:17 p.m., registered nurse (RN)-A stated the group sheets are designed to communicate what cares are needed and how to transfer each resident. R1 was an assist of one to transfer, so R1 should be transferred with a</p>	F 689	by the QA/QI committee. The Director of Nursing or designee is responsible for monitoring on-going compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 689	<p>Continued From page 3</p> <p>transfer belt, proper footwear and with her wheeled walker when ambulating.</p> <p>During an observation on 9/1/23 at 9:32 a.m., NA-B responded to R1's call light. R1 was sitting on the toilet in the bathroom with gripper socks on there feet and no transfer belt. NA-B had R1 stand using the grab bar, cares were completed and NA-B assisted with transferring to the wheelchair with out a transfer belt in place. While R1 was transferring she was shaky and rapidly sat down in the wheelchair. There was a transfer belt hanging on the outside of R1's room wardrobe.</p> <p>During an interview on 9/1/23 at 9:51 a.m., NA-B stated she normally used a transfer belt when she transferred R1 to and from the toilet. NA-B did not use a transfer belt when she assisted R1 from the toilet to her wheelchair. NA-B forgot to get the transfer belt before NA-B assisted R1 with a transfer to her wheelchair. NA-B identified she was educated and taught how to use a transfer belt. NA-B used the transfer belt with R1 because NA-B didn't want R1 to have another fall.</p> <p>On 9/1/23 at 10:02 a.m., physical therapist (PT)-A identified R1 should be an assist of one for transfers and nursing staff should use a transfer belt to transfer R1 to and from the toilet and when they assisted R1 to ambulate with her wheeled walker.</p> <p>On 9/1/23 at 11:25 a.m., TMA-B stated R1 was an assist of one for transfers and that meant staff needed to use a transfer belt when they assisted R1.</p> <p>On 9/1/23 at 1:10 p.m., director of nursing (DON)</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>stated the facility standard practice required transfer belts for all resident transfers/ambulation unless a resident refused and had a risk vs. benefit in place, or the resident had an independent status. The transfer belt would be used for guiding a standby assist resident whereas an assist of one resident may require staff to use muscle effort to correct or help a resident maintain posture and or balance. A transfer belt should be utilized when transferring R1 to and from the toilet and with ambulation.</p> <p>The facility Transfer/Lifting Policy and Procedure dated 3/23, identified transfer belts were required for all assisted non-mechanical transfers and ambulation. Apply around resident, over outer clothing and fasten snugly. The policy instruction steps for one person pivot transfers and two-person pivot transfers both instructed staff to apply a transfer belt to the resident.</p>	F 689		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 15, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: UZIY11

Dear Administrator:

The above facility was surveyed on August 31, 2023 through September 1, 2023 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

September 15, 2023

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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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 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 09/01/2023
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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 8/31/23 to 9/1/23, 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 09/22/23
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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. H52914984C (MN96233) with licensing orders issued at MN Rule 4658.0520 Subp 1. (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 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.</p>	2 000		
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2 000	Continued From page 2	2 000		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow fall interventions for 1 of 3 residents (R1) reviewed for falls.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 8/10/23, identified R1 had moderately impaired cognition. R1 needed extensive assist of one for bed mobility, transfers, toileting, and walking in room and corridor. R17's balance required corrective assistance from staff</p>	2 830	Completed	10/2/23

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2 830	<p>Continued From page 3</p> <p>with transfers and ambulation. R1 had no history falls since admission and diagnoses included hypoxemia and heart failure.</p> <p>The group sheet dated 8/23/23, utilized by nursing assistants, identified R1 was a high risk for falls does not identify use of transfer belt use.</p> <p>R1's care plan dated 8/25/23, identified a diagnosis of a T8 fracture following a recent fall and was a high risk for falls. On 8/18/23, following a 8/17/23, fall the care plan was updated to include staff to place gripper socks on at night; however, the care plan lacked direction for staff to utilize a transfer belt with all transfers and ambulation.</p> <p>On 8/31/23 at 1:00 p.m., R1 stated she had a recent fall in her room and was transferred by ambulance. Staff used the belt and it helped her transfers. R1 was still having a lot of pain when she moved, but when she was laying in bed the pain was best.</p> <p>On 8/31/23 at 2:25 p.m., trained medication aide (TMA)-A stated the group sheets told staff how to transfer residents and what care they needed. TMA-A explained when a resident was an assist of one, that meant staff needed to use a transfer belt and stand by the resident when the resident transferred or walked somewhere.</p> <p>On 8/31/23 at 2:30 p.m., licensed practical nurse (LPN)-B stated group sheets were used so that everyone knew what cares to do and how to transfer each resident. An assist of one meant staff would use a transfer belt to physically assist the resident as needed along with whatever other devices the resident needed. Staff would also use a transfer belt for residents that required stand by</p>	2 830		
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2 830	<p>Continued From page 4</p> <p>assist.</p> <p>On 8/31/23 at 2:38 p.m., nursing assistant (NA)-A stated staff worked off the group sheets. When a resident needed stand by assistance, the resident did most of the work, but staff still needed to put a transfer belt on the resident in case the resident needed help. When a resident required an assist of one, staff should hold onto to the transfer belt because staff may need to help a resident regain or maintain their balance during a transfer.</p> <p>On 8/31/23 at 2:52 p.m., LPN-A stated we put transfer belts on residents that are stand by assist, so staff have something to grab to help the resident regain their balance. If a resident is an assist of one, staff should put a transfer belt on the resident and hold onto it. Staff hold on because an assist of one may need staff to use their own strength to help the resident maintain stability and posture or to correct a loss of balance.</p> <p>On 8/31/23 at 3:17 p.m., registered nurse (RN)-A stated the group sheets are designed to communicate what cares are needed and how to transfer each resident. R1 was an assist of one to transfer, so R1 should be transferred with a transfer belt, proper footwear and with her wheeled walker when ambulating.</p> <p>During an observation on 9/1/23 at 9:32 a.m., NA-B responded to R1's call light. R1 was sitting on the toilet in the bathroom with gripper socks on there feet and no transfer belt. NA-B had R1 stand using the grab bar, cares were completed and NA-B assisted with transferring to the wheelchair with out a transfer belt in place. While R1 was transferring she was shaky and rapidly sat down in the wheelchair. There was a transfer</p>	2 830		

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2 830	<p>Continued From page 5</p> <p>belt hanging on the outside of R1's room wardrobe.</p> <p>During an interview on 9/1/23 at 9:51 a.m., NA-B stated she normally used a transfer belt when she transferred R1 to and from the toilet. NA-B did not use a transfer belt when she assisted R1 from the toilet to her wheelchair. NA-B forgot to get the transfer belt before NA-B assisted R1 with a transfer to her wheelchair. NA-B identified she was educated and taught how to use a transfer belt. NA-B used the transfer belt with R1 because NA-B didn't want R1 to have another fall.</p> <p>On 9/1/23 at 10:02 a.m., physical therapist (PT)-A identified R1 should be an assist of one for transfers and nursing staff should use a transfer belt to transfer R1 to and from the toilet and when they assisted R1 to ambulate with her wheeled walker.</p> <p>On 9/1/23 at 11:25 a.m., TMA-B stated R1 was an assist of one for transfers and that meant staff needed to use a transfer belt when they assisted R1.</p> <p>On 9/1/23 at 1:10 p.m., director of nursing (DON) stated the facility standard practice required transfer belts for all resident transfers/ambulation unless a resident refused and had a risk vs. benefit in place, or the resident had an independent status. The transfer belt would be used for guiding a standby assist resident whereas an assist of one resident may require staff to use muscle effort to correct or help a resident maintain posture and or balance. A transfer belt should be utilized when transferring R1 to and from the toilet and with ambulation.</p> <p>The facility Transfer/Lifting Policy and Procedure</p>	2 830		
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2 830	<p>Continued From page 6</p> <p>dated 3/23, identified transfer belts were required for all assisted non-mechanical transfers and ambulation. Apply around resident, over outer clothing and fasten snugly. The policy instruction steps for one person pivot transfers and two-person pivot transfers both instructed staff to apply a transfer belt to the resident.</p> <p>SUGGESTED METHOD OF CORRECTION: The 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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