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	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clare Living Community of Mora	110 North 7th Street Mora, MN 55051

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the code alert system (a wander management system to protect residents from elopement) was functioning properly, failed to follow manufacture recommendation for weekly testing, and failed to follow manufacture recommendations for inspection. This resulted in an immediate Jeopardy situation for two residents (R19, R12) who were at risk for elopement and were able to get through the main doors, due to failure of the doors to lock as required per the code alert system. In addition, the facility failed to adequately assess and develop care plans for residents identified at risk for elopement and wandering for 14 of 14 residents (R19, R12, R3, R4, R13, R17, R18, R22, R25, R28, R32, R34, R37, R46) who were assigned code alert devices and had the potential for elopement.The IJ began on [DATE] at 2:18 p.m., when R12 was able to exit the building due to code alert system malfunction. The administrator and director of nursing (DON) were notified of the IJ on [DATE], at 7:35 p.m. The immediate jeopardy was removed on [DATE] at 4:36 p.m., however, non-compliance remained at a lower scope and severity, level 2, isolated scope, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings Include:The manufacturer Code Alert System book in the facility binder recommended:-Weekly testing of the code alert units and instructed replacement of expired devices and/or devices that failed testing.-Testing of each detection zone (doors) on a regular basis, ideally weekly.-Quarterly service inspections by vendor.Logs titled Code Alert Alarm Testing dated between 1/2025, and 4/2025, showed the North internal door/offices, Main Entry/Exit Long Term, South Exit, East Exit, [NAME] Connector Exit, and the [NAME] View Entry/Exit had been tested monthly.Logs titled Wander Guard Monitor sheets dated between 1/2026, and [DATE], listed all residents with a code alert monitor, the monitor location, and the device expiration date. Device checks were documented as completed weekly. The most recent log dated 4/2026, listed 14 residents with code alert devices: R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46.R19 was admitted to the facility on [DATE]. R19' significant change MDS assessment dated [DATE], indicated R19 was severely cognitively impaired with the diagnosis of Alzheimer's disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R19 had not exhibited wandering. R19's care plan reviewed [DATE], lacked interventions for elopement and wandering.R19's most recent elopement assessment was completed on [DATE]. The assessment identified R19 as low risk for elopement and interventions included clothing labeled with identification, identification band on resident. The Door Alarm band applied (code alert device) was not selected. R19's progress note did not include an entry regarding R19's attempt to leave the building on [DATE].During an observation on [DATE] at 10:07 a.m., R19 wheeled their wheelchair to the main entrance of the facility. R19 proceeded to wheel self through the first door into the entrance vestibule. The alarm went off, but the door did not lock. NA-J responded and was able to redirect R19 out of the entry and back to the central tv area. R19 was heard telling NA-J I was just thinking about a change of scenery. Oh, sure let's go to the tv area. R19's code alert device was attached above the left wheel of their wheelchair.During an interview on [DATE] at 10:48 a.m., nursing assistant NA-J (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated yesterday they had heard the alarm go off and had responded to the main entry. R19 had been partially through the first door when they reached R19. Usually, the door would lock when a resident got withing 3 feet or so, but it had not locked yesterday.R12 was admitted to the facility on [DATE]. R12's quarterly MDS assessment dated [DATE], indicated R12 was severely cognitively impaired with diagnoses of non-Alzheimer's dementia and anxiety. MDS Section P. indicated a wander guard alarm was not in use. Section E900 indicated R12 had not exhibited wandering. R12's care plan last reviewed [DATE], lacked interventions for elopement and wandering.R12 had documented elopement assessments completed by the licensed social worker (LSW-A) on [DATE], [DATE], [DATE].R12's most recent assessment completed on [DATE], indicated R12 was a low risk for elopement and interventions in place included: clothing labeled, and an identification band placed on the wrist. The door alarm band applied (code alert device) was not selected as an intervention.During an observation on [DATE] at 8:40 a.m., R12 set off code-alert alarm attempting to ambulate out the main facility door. R12 went through the inside door into the vestibule where her walker got hung up on the rug pushing it upwards along the legs of the walker. Staff responded and redirected R12 back inside and away from the entrance door.During an observation on [DATE] at 2:18 p.m., R12 walked out of their room with their wheeled walker directly to the main entrance. R12 paused at the main entrance door, stated I think my car is out there and then proceeded through the first door. R12's walker initially got caught up on the rug, but R12 was able to push walker beyond the rug and proceeded outside. Staffing coordinator (SC)-D saw R12 exiting the building and followed R12 out asking that surveyors 1 or 2 get their cell phone and bring it to them. Surveyor 2 notified the DON who was passing down the hallway a resident had made it outside of the building and SC-D had followed and needed their phone. The DON brought the phone out to SC-D and left the area. SC-D and R12 sat on a bench along the driveway. At 2:20 p.m., SC-D and R12 came back inside the facility. R12 returned to their room which was near the main entrance doorDuring an observation on [DATE] at 9:07 a.m., R12 walked out of their room to the main entrance door. R12 made it through the first door and into the vestibule before SC-D redirected R12 back inside and away from the door. The alarm went off once R12 went through the first door. SC-D stated they were keeping a staff at the door 24/7 until the door was fixed.Progress notes entered by LSW-A on [DATE], [DATE], and [DATE], indicated R12's elopement assessments had been reviewed with no change. R12's EMR lacked documentation regarding R12's successful exit of the building on [DATE], or their attempts to exit the building made on [DATE], and [DATE].On [DATE] at 2:20 p.m., the maintenance department responded to a call regarding the door. The director of plant services (DPS)-A stated the door should have locked when R12 got near it, and once R12 made it through the door the door should have alarmed.During an interview on [DATE] at 2:23 p.m., SC-D stated they had seen R12 heading to the door, initially they thought it had locked, but then R12 went through the door, and it didn't alarm so they followed R12 outside. R12 agreed to come back in for coffee so they had brought R12 coffee when they came back in.On [DATE] at 2:30 p.m., DPS-A and maintenance associate (MA-B) started adjusting and testing the main entrance door code alert system. The door continued to fail with testing and readjusting.During an interview on [DATE] at 2:56 p.m., SC-D stated R12 had a history of trying to get out of the facility. Usually when R12 tried to leave, R12 was looking for their car, house, or family. Lately R12 had been attempting to leave more frequently.During an interview on [DATE] at 3:08 p.m., occupational therapist (OT)-C stated R12 was able to walk from her room to the dining room and back again.During an interview on [DATE] at 3:51 p.m., NA-A stated she was familiar with R12 and said she was able to walk around the facility using her walker. NA-A stated R12 could walk to activities using her walker. NA-A stated R12 would try to leave the facility a lot, mostly in the evenings. NA-A stated she would want to go pick up her kids, when this occurred, they would call her son, and he would come over. NA-A stated she was not aware of her ever leaving the building.During an interview on [DATE] at 3:55 p.m., NA-C stated R12 could walk on her own using her walker, stated she was a good walker. NA-C stated R12 would try to leave the building mostly in the evening. NA-C stated she had seen R12 leave the building about a month (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	previously, stated she got between the inner and outside door, the alarm sounded.During an interview on [DATE] at 4:01 p.m., NA-D stated R12 walked independently using a walker. NA-D stated she would try to leave the building and stated the evening before she was crying, trying to find her baby and asking how to get out of the building. She was not successful.During an interview on [DATE] at 4:05 p.m., NA-E stated R12 walked independently using a walker. NA-E was not aware of her trying to leave the building but stated last summer she was wanting to go outside.During an interview on [DATE] at 4:08 p.m., trained medication aide (TMA)-A stated R12 would wait by the door waiting for her son to come and pick her up. TMA-A stated the waiting by the door occurred mostly in the evenings after supper.During an interview on [DATE] at 4:14 p.m., LPN-A stated she had caught R12 a few times trying to leave the building, said she would usually come back in easily and then they would call her son. LPN-A stated R12 could walk independently using a walker, stated she would get between the doors, and the alarm would sound.On [DATE] at 4:19 p.m., MA-B stated the manual identified electronics could potentially interfere with the functioning of the code alert system. All technology was removed from the dining area and the meeting room on either side of the main entrance door. MA-B proceeded to test the door; however, the door did not lock or alarm when approached with a code alert device.During an interview on [DATE] at 4:20 p.m., NA-F stated R12 would get things ready and say someone was coming to pick her up. NA-F stated R12 was able to walk around the building independently using her walker.During an interview on [DATE] at 4:25 p.m., LPN-B said R12 would try to leave the building about four to five times a week. LPN-B stated R12 get around the building independently using her walker.During an interview on [DATE] at 9:02 a.m., SC-D stated on 4/28 they had been at the nurse's station when R12 had set the door alarm off. Normally the door would have locked so R12 couldn't get through the first door. When they responded with another staff, R12 had already made it out between the doors. R12 said they were looking for the salon when we got her.During an interview on [DATE] at 4:29 p.m., SC-D stated Monday through Friday, she would be seated at the desk across from the front door from 8:00 a.m. to 4:30 p.m. The charge nurse would be responsible to lock the front door on the evening shift. SC-D stated R12 will try to leave the building, not usually as much as this week. SC-D recalled last summer R12 got between the two doors. SC-D stated R12 walked independently using a walker.During an interview on [DATE] at 3:38 p.m., the DON stated R12 has had increased confusion and behaviors regarding looking for and being worried about their son. It was a significant change in R12's disease progression for R12 to not know where their apartment was (that was what R12 called their room). The team had discussed R12's inability to navigate to their room and felt it would be beneficial to move R12 to a room where they did not have to pass the main entrance when going to and from their room. They planned to discuss the potential room change with R12's son.R3 was admitted on [DATE]. R3's quarterly MDS assessment dated [DATE], indicated R4 was severely cognitively impaired with a diagnosis of dementia neurocognitive Lewy body disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R4 had not exhibited wandering. R3's care plan last reviewed on [DATE] lacked interventions for elopement and wandering.R4 was admitted on [DATE]. R4's quarterly MDS assessment dated [DATE], indicated R4 was severely cognitively impaired with diagnoses of Alzheimer's disease and non-traumatic brain dysfunction. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. indicated R4 had not exhibited wandering. R4's care plan last reviewed [DATE], lacked interventions for elopement and wandering.R13 was admitted on [DATE]. R13's quarterly MDS assessment dated [DATE], indicated R13 was moderately cognitive impaired with the diagnoses of dementia, anxiety, and cognitive impairment. Section E900. did not identify wandering behavior. Section P. indicated a wander device was not in use. R13's care plan last revised [DATE], did not include elopement or wandering intervention. On [DATE], R13's elopement assessment was completed and R13's code alert device was removed.R17 was admitted on [DATE]. R17's quarterly MDS dated [DATE], indicated R17 was moderately cognitively impaired with the diagnoses of dementia, and anxiety. Section E900. Indicated R17 had not exhibited wandering (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4:30 p.m. The charge nurse would be responsible to lock the front door on the evening shift. SC-D stated R12 will try to leave the building, not usually as much as this week. SC-D recalled last summer R12 got between the two doors. SC-D stated R12 walked independently using a walker.During an interview on [DATE] at 3:38 p.m., the DON stated R12 has had increased confusion and behaviors regarding looking for and being worried about their son. It was a significant change in R12's disease progression for R12 to not know where their apartment was (that was what R12 called their room). The team had discussed R12's inability to navigate to their room and felt it would be beneficial to move R12 to a room where they did not have to pass the main entrance when going to and from their room. They planned to discuss the potential room change with R12's son.During an interview on [DATE] at 1:39 p.m., NA-G stated if a resident had wandering or elopement risks that would be identified on the care plan. All staff watched for and redirected those behaviors. If a resident got too close to the main door, it locked and alarmed to alert staff to respond and redirect. Once the alarm went off it had to be reset to stop alarming and unlock the door.During an interview on [DATE] at 1:46 p.m., NA-B stated as a NA they didn't do anything with the code alert alarm devices on residents. The hydration NA went around once a week and checked to make sure the code alert devices were still working.During an interview on [DATE] at 1:54 p.m., NA-A stated another staff was the primary for testing resident code alert devices, but they had been trained and could do it if asked.During an interview on [DATE] at 2:14 p.m., licensed practical nurse (LPN-C) stated the facility kept a book of resident's who had code alert alarms at (SC)-D's desk by the main entrance. As an LPN, they were not assigned any assessments or checks for the code alert devices, the hydration NAs were the ones who went around and checked to make sure the devices were working. R3 had a code device on their ankle, and they were the only resident with ordered daily placement checks.During an interview on [DATE] at 11:41 a.m., RN-A stated residents got code alert devices placed if/when they were identified as having wandering/elopement behaviors and they could not be safe alone outside. The social worker was responsible for doing the wander/elopement assessments. There is always a concern a resident could elope because no system was fail proof. If a visitor went out the main door a resident could get out behind them. The alarm should go off if a resident makes it past the first door. NAs should know who has a code alert device and those residents should be watched closely. Wander and elopement risks should be added to the care plan with care interventions. Elopement attempts and behaviors should be documented in progress notes especially if the resident makes it out of the facility or past the first door. The NAs should also chart events in the behavior section of their charting. There should be progress notes about R12 and R19's attempts to leave.During an interview on [DATE] at 8:57 a.m., DPS-A said they had been called to check the main door. SC-D stated they had called DPS-A because they didn't see the yellow light sensor that meant the main door code alert system was working. DPS-A held a resident code alert devise and walked to the main entry door and was able to walk into the vestibule between the outermost door and the inner door on the facility side of the vestibule. Once inside the vestibule, the inner door back into the facility locked. DPS-A could not get back into the facility until the alarm was reset. DPS-A explained the facility side door locked when the alarm was triggered. The Door to the outside of the building did not lock, so if a resident made it past the inside door into the vestibule, they would be able to proceed out of the building through the outer door. The system had adjustable sensors [canoes] on both sides of the doors that required adjustment so when a resident with an alert device got close to the door it would lock and if a resident made it through the first door or it was open, then the system alarmed. Humidity could affect the sensors as well as how they were set. DPS-A did a second system test. DPS-A walked up to the door and was able to make it through the first door. DPS-A stated the system hadn't locked the door because they had approached the door too quickly. DPS-A did a slower approach with the same result and then adjusted the canoes (sensors on either side of the door that sense the wearable dvice). DPS-A approached the door two more times, and the door locked appropriately both times.During a follow-up interview on [DATE] at 9:04 a.m., DPS-A stated the system had last been (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	area that is already on the care plan such as fall risk or cognition.During an interview on [DATE] at 2:08 p.m., the administrator stated they had not been notified of R19 and R12's attempts to exit the building. Leadership and maintenance should have been notified when R12 and R19 were able to get past the first door. They expected staff to notify maintenance anytime a door didn't seem to be functioning correctly so maintenance could service the door immediately. They had discussed the code alert system with DPS-A and decided they would start doing weekly door testing as recommended in the manual.The immediate jeopardy was removed on [DATE] at 4:36 p.m., when the facility scheduled maintenance for the call alert system, placed staff at the door to monitor the system at all times when the door was not locked, updated resident assessment and care plans for residents who used a code alert device, revised their Code Alert System policy, and educated staff on reporting failures in the call alert system.The facility policy Code Alert System dated 9/2017, identified the code alert transponder devices were to be tested weekly and the door function was to be tested by maintenance monthly. Malfunctions or repairs made were to be reported to the administrator and nursing along with the current status of the system and need for special monitoring due to delay in repairs. The policy did not address malfunctions and actions to be taken for malfunctions outside of monthly testing. Nor did it address down time procedures for malfunction of the system or doors.The facility policy Elopement dated 1/2023, identified residents known to wander and or who have cognitive deficits may wear the signaling device which activates an alarm should they leave the facility. Staff instruction for resident elopement was outlined in the policy. The policy did not include instruction to staff for reporting code alert system malfunctions or alternative actions to be implemented during code system malfunctions.

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St Clare Living Community of Mora	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure accurate MDS coding of the use of a code alert device occurred for 14 of 14 residents (R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, R46) who were identified as at risk for elopement and wandering. Findings include:The code alert system log titled Wander Guard Monitor dated 4/2026, identified the following 14 residents as having a code alert device: R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46.R3 was admitted on [DATE]. R3's quarterly MDS assessment dated [DATE], indicated R4 was severely cognitively impaired with a diagnosis of dementia neurocognitive Lewy body disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R4 had not exhibited wandering. R3's care plan last reviewed on 3/16/26 lacked interventions for elopement and wandering.R4 was admitted on [DATE]. R4's quarterly MDS assessment dated [DATE], indicated R4 was severely cognitively impaired with diagnoses of Alzheimer's disease and non-traumatic brain dysfunction. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. indicated R4 had not exhibited wandering. R4's care plan last reviewed 4/6/26, lacked interventions for elopement and wandering.R13 was admitted on [DATE]. R13's quarterly MDS assessment dated [DATE], indicated R13 was moderately cognitive impaired with the diagnoses of dementia, anxiety, and cognitive impairment. Section E900. did not identify wandering behavior. Section P. indicated a wander device was not in use. R13's care plan last revised 4/16/26, did not include elopement or wandering intervention. On 5/1/26, R13's elopement assessment was completed and R12's code alert device was removed.R17 was admitted on [DATE]. R17's quarterly MDS dated [DATE], indicated R17 was moderately cognitively impaired with the diagnoses of dementia, and anxiety. Section E900. Indicated R17 had not exhibited wandering behavior. Section P. indicated a wander device was not in use. R17's care plan last updated 4/6/26, did not include elopement or wandering interventions. An Elopement assessment was completed on 5/1/26 and R17's code alert device was removed.R18 was admitted on [DATE]. R18's quarterly MDS assessment dated [DATE], indicated R18 was moderately cognitively impaired with a diagnosis of Alzheimer's disease. MDS Section P. indicated a wander guard alarm was not in use. Section E900. indicated R18 had not exhibited wandering. R18's care plan was last reviewed 4/21/26, did not include interventions for elopement and wandering. R22 was admitted on [DATE]. R22's quarterly MDS assessment dated [DATE], indicated R22 was severely cognitively impaired with diagnosis of vascular dementia with other behavioral disturbances. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. identified R22 had not exhibited wandering. R22's care plan last reviewed 3/5/26, lacked interventions for elopement and wandering and did not identify the placement location or R22's code alert device.R23 was admitted on [DATE]. R23's admission MDS dated [DATE], indicated R23 was severely cognitively impaired with the diagnoses of anxiety disorder, unspecified head injury and type 2 diabetes. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R23's care plan last reviewed on 4/28/26, lacked interventions for elopement and wandering.R28 was admitted on [DATE]. R28's MDS assessment dated [DATE], indicated R28 was severely cognitively impaired with the diagnosis of dementia. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R28's care plan last reviewed on 4/6/26, lacked interventions for elopement and wandering.R32 was admitted on [DATE]. R32's annual MDS assessment dated [DATE], indicated R32 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and dementia with behavior disturbances. MDS Section E0900. indicated R32 had not exhibited wandering behavior. Section P. did not indicate R32 had a wander guard. R32's care plan last reviewed 2/16/26, lacked interventions for elopement or wandering.R34 was admitted [DATE]. R34's quarterly MDS dated [DATE], indicated R34 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and diabetes type 2. MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section E0900. indicated R34 had not exhibited wandering behavior. Section P. did not indicate R34 had a wander guard. R34's care plan last reviewed 4/5/26, lacked interventions for elopement and wandering.R37 was admitted [DATE]. R37's quarterly MDS dated [DATE], indicated R37 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R37 had not exhibited wandering behavior. Section P. did not indicate R37 had a wander guard. The problem area elopement was not initiated on R37's care plan until 5/1/26.R46 was admitted on [DATE], and was discharged on 4/20/26. R46's significant change MDS assessment dated [DATE], indicated R46 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R46 had not exhibited wandering behavior. Section P. did not indicate R46 had a wander guard. R46's care plan was requested but not received.R19 was admitted to the facility on [DATE]. R19' significant change MDS assessment dated [DATE], indicated R19 was severely cognitively impaired with the diagnosis of Alzheimer's disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R19 had not exhibited wandering. R19's care plan reviewed 2/10/26, lacked interventions for elopement and wandering.R19's most recent elopement assessment was completed on 2/9/26. The assessment identified R19 as low risk for elopement and interventions included clothing labeled with identification, identification band on resident. The Door Alarm band applied (code alert device) was not selected. R19's EMR lacked evidence to show elopement assessments had been performed quarterly.R12 was admitted to the facility on [DATE]. R12's quarterly MDS assessment dated [DATE], indicated R12 was severely cognitively impaired with diagnoses of non-Alzheimer's dementia and anxiety. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R12 had not exhibited wandering. R12's care plan last reviewed 4/16/26, lacked interventions for elopement and wandering.R12 had documented elopement assessments completed by the licensed social worker (LSW-A) on 10/27/23, 9/15/24, 8/18/25.R12's most recent assessment completed on 8/18/25, indicated R12 was a low risk for elopement and interventions in place included: clothing labeled, and an identification band placed on the wrist. The door alarm bad applied (code alert device) was not selected as an intervention. R12's EMR lacked evidence quarterly elopement assessments had been completed.Progress notes entered by LSW-A on 10,30/25, 1/22/26, and 4/16/26, indicated R12's elopement assessments had been reviewed with no change. R12's EMR lacked documentation regarding R12's successful exit of the building on 4/30/26, or their attempts to exit the building made on 4/28/26, and 5/1/26. During an interview on 4/29/26 at 1:39 p.m., NA-G stated if a resident had wandering or elopement risks that would be identified on the care plan.During an interview on 4/29/26 at 2:14 p.m., LPN-C stated the facility kept a book of resident's who had code alert alarms at SC-D's desk by the main entrance. As an LPN, they were not assigned any assessments or checks for the code alert devices.During an interview on 4/30/26 at 9:26 a.m., registered nurse (RN)-B verified section P of the quarterly MDS dated [DATE], did not identify R3 had a wanderguard in use. RN-B stated they never code them. RN-B stated she saw there was a wanderguard in use from reviewing the nursing assistant group sheets but again said they have never coded the wanderguards. RN-B stated the purpose of the MDS was to identify payment, create a picture of all aspects of the resident's life and stated it would help in creating a care plan for the resident(s).During an interview on 4/30/26 at 11:41 a.m., RN-A stated residents got code alert devices placed if/when they were identified as having wandering/elopement behaviors and they could not be safe alone outside. Wander and elopement risks should be added to the care plan with care interventions. Elopement attempts and behaviors should be documented in progress notes especially if the resident made it out of the facility or past the first door. The NAs should also chart events in the behavior section of their charting. The MDS nurse could access behavior charting and the care plan to know who had code alert.During an interview on 4/30/26 at 12:54 p.m., the DON stated elopement assessments were reviewed quarterly. Assessments should be re-done if a resident had an event between quarterly assessments or a change from the last quarterly assessment. Resident care (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plans should include the location of the code alert device and resident specific elopement and wandering interventions. The MDS should be coded to reflect code alert placement because MDS drives the care/care plan.The undated, facility policy Care Planning-IDT identified the care plan was based on the resident's comprehensive MDS assessment.MDS policies were requested but not received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to develop a comprehensive care plan with individualized elopement and wandering interventions with review and revision after subsequent MDS assessments or elopement status changes for 14 of 14 residents (R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, R46) who were identified as at risk for elopement and wandering. In addition, the facility failed to care plan necessary interventions for 3 of 3 residents (R7, R14, and R26) who were addressed for care planning.Findings include: The code alert system log titled Wander Guard Monitor dated 4/2026, identified 14 residents who had code alert devices: R3, R4, R12, R13, R17, R18, R19, R22, R25, R28, R32, R34, R37, and R46. R3 was admitted on [DATE]. R3's quarterly MDS assessment dated [DATE], indicated R4 was severely cognitively impaired with a diagnosis of dementia neurocognitive Lewy body disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R4 had not exhibited wandering. R3's care plan last reviewed on 3/16/26 lacked interventions for elopement and wandering. R4 was admitted on [DATE]. R4's quarterly MDS assessment dated [DATE], indicated R4 was severely cognitively impaired with diagnoses of Alzheimer's disease and non-traumatic brain dysfunction. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. indicated R4 had not exhibited wandering. R4's care plan last reviewed 4/6/26, lacked interventions for elopement and wandering. R13 was admitted on [DATE]. R13's quarterly MDS assessment dated [DATE], indicated R13 was moderately cognitive impaired with the diagnoses of dementia, anxiety, and cognitive impairment. Section E900. did not identify wandering behavior. Section P. indicated a wander device was not in use. R13's care plan last revised 4/16/26, did not include elopement or wandering intervention. On 5/1/26, R13's elopement assessment was completed and R13's code alert device was removed. R17 was admitted on [DATE]. R17's quarterly MDS dated [DATE], indicated R17 was moderately cognitively impaired with the diagnoses of dementia, and anxiety. Section E900. Indicated R17 had not exhibited wandering behavior. Section P. indicated a wander device was not in use. R17's care plan last updated 4/6/26, did not include elopement or wandering interventions. An Elopement assessment was completed on 5/1/26 and R17's code alert device was removed. R18 was admitted on [DATE]. R18's quarterly MDS assessment dated [DATE], indicated R18 was moderately cognitively impaired with a diagnosis of Alzheimer's disease. MDS Section P. indicated a wander guard alarm was not in use. Section E900. indicated R18 had not exhibited wandering. R18's care plan was last reviewed 4/21/26, did not include interventions for elopement and wandering. R22 was admitted on [DATE]. R22's quarterly MDS assessment dated [DATE], indicated R22 was severely cognitively impaired with diagnosis of vascular dementia with other behavioral disturbances. MDS. Section P. indicated a wander guard alarm was not in use. Section E900. identified R22 had not exhibited wandering. R22's care plan last reviewed 3/5/26, lacked interventions for elopement and wandering and did not identify the placement location or R22's code alert device. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23 was admitted on [DATE]. R23's admit MDS dated [DATE], indicated R23 was severely cognitively impaired with the diagnoses of anxiety disorder, unspecified head injury and type 2 diabetes. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R23's care plan last reviewed on 4/28/26, lacked interventions for elopement and wandering. R28 was admitted on [DATE]. R28's MDS assessment dated [DATE], indicated R28 was severely cognitively impaired with the diagnosis of dementia. MDS Section E0900. indicated R23 had not exhibited wandering behavior. Section P. did not indicate R23 had a wander guard. R28's care plan last reviewed on 4/6/26, lacked interventions for elopement and wandering. R32 was admitted on [DATE]. R32's annual MDS assessment dated [DATE], indicated R32 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and dementia with behavior disturbances. MDS Section E0900. indicated R32 had not exhibited wandering behavior. Section P. did not indicate R32 had a wander guard. R32's care plan last reviewed 2/16/26, lacked interventions for elopement or wandering. R34 was admitted [DATE]. R34's quarterly MDS dated [DATE], indicated R34 was significantly cognitively impaired with the diagnoses of Alzheimer's disease and diabetes type 2. MDS Section E0900. indicated R34 had not exhibited wandering behavior. Section P. did not indicate R34 had a wander guard. R34's care plan last reviewed 4/5/26, lacked interventions for elopement and wandering. R37 was admitted [DATE]. R37's quarterly MDS dated [DATE], indicated R37 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R37 had not exhibited wandering behavior. Section P. did not indicate R37 had a wander guard. The problem area elopement was not initiated on R37's care plan until 5/1/26. R46 was admitted on [DATE], and discharged from the facility on 4/20/26. R46's significant change MDS assessment dated [DATE], indicated R46 was significantly cognitively impaired with the diagnosis of Alzheimer's disease. MDS Section E0900. indicated R46 had not exhibited wandering behavior. Section P. did not indicate R46 had a wander guard. R46's care plan was requested but not received. R19 was admitted to the facility on [DATE]. R19' significant change MDS assessment dated [DATE], indicated R19 was severely cognitively impaired with the diagnosis of Alzheimer's disease. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R19 had not exhibited wandering. R19's care plan reviewed 2/10/26, lacked interventions for elopement and wandering. R19's most recent elopement assessment was completed on 2/9/26. The assessment identified R19 as low risk for elopement and interventions included clothing labeled with identification, identification band on resident. The Door Alarm band applied (code alert device) was not selected. R12's quarterly MDS assessment dated [DATE], indicated R12 was severely cognitively impaired with diagnoses of non-Alzheimer's dementia and anxiety. MDS. Section P. indicated a wander guard alarm was not in use. Section E900 indicated R12 had not exhibited wandering. R12's care plan last reviewed 4/16/26, lacked interventions for elopement and wandering. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12 had documented elopement assessments completed by the licensed social worker (LSW-A) on 10/27/23, 9/15/24, 8/18/25. R12's most recent assessment completed on 8/18/25, indicated R12 was a low risk for elopement and interventions in place included: clothing labeled, and an identification band placed on the wrist. The door alarm bad applied (code alert device) was not selected as an intervention. During an interview on 4/29/26 at 1:39 p.m., NA-G stated if a resident had wandering or elopement risks that would be identified on the care plan. All staff watched for and redirected those behaviors. During an interview on 4/30/26 at 11:41 a.m., registered nurse (RN-A) stated residents got code alert devices placed if/when they were identified as having wandering/elopement behaviors and they could not be safe alone outside. NAs should know who has a code alert device and those residents should be watched closely. It was the licensed social worker's (LSW-A) responsibility to complete Elopement risk assessments. If nurses initiated a code alert device they would then notify the SW to complete the assessment. Devices were typically placed on resident assistive devices like wheelchairs, walkers, or canes. Once a week the hydration NA went around and checked each device battery to make sure it was still working. There were no other routine nursing assessments or placement checks done associated with the code alerts by nursing. R3 was the only resident with an ankle placement and ordered daily placement checks. Wander and elopement risks should be added to the care plan with care interventions. Elopement attempts and behaviors should be documented in progress notes especially if the resident made it out of the facility or past the first door. The NAs should also chart events in the behavior section of their charting. There should be progress notes about R12 and R22's attempts to leave. The MDS nurse and the social worker have access to the behavior charting. During an interview on 4/30/26 at 12:54 p.m., the DON stated elopement assessments were reviewed quarterly. Assessments should be re-done if a resident had an event between quarterly assessments or a change from the last quarterly assessment. Resident care plans should include the location of the code alert device and resident specific elopement and wandering interventions. Residents who eloped or exhibited wandering or elopement behaviors, and or had had lower cognition or other risk factors that put that at risk if they were to leave the building were assigned code alert devices. It was LSW's responsibility to complete the elopement assessments. Nurses had the ability to place a code alert device and then notify the LSW an assessment needed to be completed. The DON stated they were not sure if a new assessment was completed if a resident eloped or attempted to leave like R12 and R19 had. The MDS should be coded to reflect code alert placement because it drives the care plan and care. During an interview on 4/30/26 at 1:14 p.m., LSW-A stated they were responsible for completing elopement risk assessments. Assessments were done on admit to determine if a resident should have a code alert device placed. Assigning low, medium or high risk for elopement was a judgment call, there was not criteria or a tool for assigning a risk level. New elopement assessments were not typically done after an attempt or elopement event if the resident already had a code alert device. However, a new quarterly elopement assessment would be done when due for any residents who had behavior changes or an event. Elopement behaviors and interventions did not get added to resident care plans, but that would be ideal. At present just the location of the code alert device like on walker etc. gets added to a problem area that is already on the care plan such as fall risk or cognition. The facility policy Elopement dated 1/2023, identified residents known to wander and or who have cognitive deficits may wear the signaling device which activates an alarm should they leave the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility. Staff instruction for resident elopement was outlined in the policy. The policy did not address elopement assessment completion or frequency. The undated, facility policy Care Planning -IDT instructed a comprehensive care plan was to be developed within seven days of completion of the MDS. The facility policy Code Alert System dated 9/2017 procedure section instructed nurses to perform resident assessment of ambulation, cognitive reasoning, and mental capacity. Residents identified as at risk will have potential risk for elopement addressed in the care plan and a code alert transponder applied to person or device. R7: R7's quarterly Minimum Data Set (MDS) dated [DATE], identified he was moderately cognitively intact and had diagnoses which included heart failure (a chronic condition where the heart muscle cannot pump blood effectively to meet the body's needs for oxygen), diabetes mellitus, anemia, insomnia, and chronic atrial fibrillation (a heart arrhythmia where the upper chambers of the heart beat rapidly and irregularly). In addition, R7's MDS identified he was taking an antidepressant. R7's current physician order report dated 4/1/26- 4/30/26, identified R7 was on the following medication: Trazadone 50 milligrams (mg), instructions identified to take at bedtime for sleep disturbance started on 1/21/26. R7's care plan dated 1/8/26, did not address sleep disturbance or antidepressant use. R7's electronic medication record dated 4/1/26-4/30/26, identified R7 received trazadone every night except 4/30/26. During an interview on 4/30/26 at 9:23 a.m., registered nurse (RN)-A reviewed the electronic medical record and verified there was nothing documented in R7's care plan for sleep or antidepressant use. RN-A stated it was important to have this information in the care plan to guide staff in caring for the resident. R14: R14's quarterly MDS dated [DATE], identified R14 was moderately cognitively intact and had diagnoses which included chronic obstructive pulmonary disease (COPD [a lung condition that causes long-term breathing problems by limiting air flow]), heart failure, tobacco use, Alzheimer's, chronic cough, and panlobular emphysema (a severe chronic, and irreversible type of COPD). In addition, R14's MDS identified verbal behaviors and rejection of care. R14's nursing assistant group sheet, dated 4/28/26, did not identify she smoked. R14's care plan dated 2/11/26, did not address smoking. During an observation on 4/27/26 at 3:30 p.m., R14 was wheeled out the front door by staff, she sat in her wheelchair just outside the front door and smoked a cigarette. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/27/26 at 4:45 p.m., R14 was brought out the front door by staff where she smoked a cigarette. During an interview on 4/30/26 at 8:59 a.m., registered nurse (RN)-A stated the resident care plans should be updated as part of the care conference. RN-A stated the facility did allow residents to smoke and said they did accept residents who smoked. RN-A reviewed R14's care plan and verified there was nothing in the care plan that addressed smoking for R14. During an interview on 4/30/26 at 9:39 a.m., the director of nursing (DON) verified they did allow residents to smoke and stated it should have been addressed in the care plan. The DON stated it was important for staff to know if a resident smoked for safety considerations. During an interview on 4/30/26 at 10:15 a.m., nursing assistant (NA)-B reviewed the group sheet for R14 and verified there was nothing to identify she smoked. Smoking Policy-Residents dated 3/2025, identified the facility would establish and maintain safe resident and smoking practices. The policy identified the resident's ability to smoke safely would be re-evaluated quarterly and upon a significant change. R26: R26's annual MDS dated [DATE], identified he was cognitively intact and had diagnoses which included hypertension, chronic kidney disease stage 5 with dependence on renal dialysis (a life-sustaining medical treatment that filters waste products, toxins, and excess fluids from the blood when the kidneys have failed), diabetes mellitus, chronic pain, morbid obesity, anxiety, COPD, cardiac pacemaker, and depressive disorder. In addition, R26's MDS identified he was receiving dialysis services. R26's nursing assistant group sheet, dated 4/28/26, did not identify in the safety column that he was on enhanced barrier precautions. During an interview on 4/30/26 at 9:37 a.m., the DON stated she would need to check with the infection preventionist to see if R26 needed to be in enhanced barrier precautions (EBP) based on his dialysis access site. The DON stated EBP would be used to protect any resident who had a wound, catheter, tube feeding, or a peripheral inserted central catheter. During an interview on 4/30/26 at 10:12 a.m., the infection preventionist (IP) reviewed R26's care plan and verified EBP were not part of the care plan. The IP stated she would expect a resident with a Quinton catheter (a large-bore, double-lumen central venous catheter designed for rapid blood flow in hemodialysis) to be in EBP and part of the care plan. The IP stated EBP are meant to protect the resident from infection. During an interview on 4/30/26 at 10:15 a.m., NA-B stated R26 should be in EBP and staff should be gowning up to perform any hands-on care. Enhanced Barrier Precautions dated 4/2024, identified the purpose of EBP was to reduce the spread of multidrug resistant organisms (MDRO). The policy identified EBP should be used if a resident had an indwelling medical device regardless of MDRO colonization. The policy identified EBP would be used during high contact resident care activities. (continued on next page)

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	05/01/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plans, Comprehensive Person-Centered Care no date, identified the plan would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. In addition, the plan would be developed from a thorough analysis of the information gathered as part of the comprehensive assessment. During an interview on 4/30/26 at 12:37 p.m., the DON stated the care plans should be addressed quarterly with the care conference and they should include information about smoking, wanderguard use, enhanced barrier precautions, and medication use (including use of an antidepressant). The DON stated this was important for direct care staff to have the information for safety, quality of life, and to address their needs and preferences for care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure proper hand hygiene and use of an ice scoop was followed during the snack pass. This deficient practice affected 3 of 3 residents (R29, R30, R7) and any other residents who received snacks during the snack pass. Finding include:R29's comprehensive Minimum Data Set (MDS) dated [DATE], identified she was moderately cognitively intact and had diagnoses which included heart disease, hypertension, hyperlipidemia, and gastroesophageal reflux disease.R30's quarterly MDS dated [DATE], identified she was moderately cognitively intact and had diagnoses which included heart failure (a chronic serious condition in which the heart muscle cannot pump enough blood to meet the body's needs for oxygen), diabetes mellitus and depression.R7's quarterly MDS dated [DATE], identified he was moderately cognitively intact and had diagnoses which included heart failure and diabetes mellitus.During an observation on 4/29/26 at 1:56 p.m., nursing assistant (NA)-A had a snack cart with two over-sized plastic pitchers filled with ice. NA-A stopped the cart outside of R29's room, NA-A was not wearing gloves entered the room, brought out the water cup, filled the water cup with ice using a plastic water glass, NA-A put the plastic glass back into the over-sized pitcher with ice, exited the room and did not perform hand hygiene. NA-A proceeded to R7's room and did not perform hand hygiene, entered the room brought out the water cup filled it with ice using the plastic water glass that was resting on top of the ice, poured juice into a cup, brought the water cup, the juice, a bag of chips and brought the items into R7's room. NA-A exited the room; no hand hygiene was performed. NA-A went into R30's room after knocking asked if they wanted any snacks, exited the room with a plate with food on it and put the plate and food into the garbage bag attached to the snack cart. NA-A did not perform hand hygiene, picked up a banana and brought it into R30's room, exited the room. No hand hygiene was performed.During an interview on 4/29/26 at 2:01 p.m., NA-A stated they took the snack cart around to rooms twice daily. NA-A verified she would put the plastic water glass back into the over-sized pitcher with ice and stated, it doesn't touch anything. NA-A verified they did not perform hand hygiene before or after exiting resident rooms or after disposing of uneaten food removed from R30's room.During an interview on 4/30/26 at 9:42 a.m., the director of nursing (DON) stated she would expect staff to perform hand hygiene before entering and after exiting a resident room. The DON stated using a plastic water glass to fill water cups coming from resident rooms and then putting the plastic water cup back into the over-sized ice pitcher was an infection control concern. Hand Hygiene dated 6/2019, identified all employees would be trained on hand hygiene practices. The policy identified hand hygiene would be performed before and after handling food and after handling soiled utensils or equipment.

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	245291	A. Building B. Wing	05/01/2026

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure resident preferences for nail care were honored for 1 of 1 resident (R8).Findings include:R8's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R8 was moderately cognitively impaired with the diagnoses of non-Alzheimer's dementia, renal insufficiency, hypertension, and depression.R8's care plan last reviewed 3/26/26 indicated R8 had limited range of motion in their upper extremities and required an assist of 1 for daily bathing, weekly showers, daily grooming, oral care, and dressing.R8's progress notes indicated R8 had last had a shower on 4/3/26. Nail care was not addressed in progress notes.During an observation on 4/28/26 at 12:48 p.m., R8 was seated in wheelchair in room with their tv remote partially on their bedside table between their hands. Noted tremor in both hands, fingernails were long beyond tips of fingers. R8 stated they were trying to get their remote onto the bedside table, but their hands were so bad they couldn't do it. There was a nail clipper on the left side of R8's bedside table. R8 stated they had the nail clipper there because they wanted to have their nails trimmed, they were too long. R8 stated they couldn't trim their nails, so they had asked staff, but nobody had done it so far.During an interview on 4/29/2026 at 8:57 a.m., R8 stated staff had trimmed their nails before, but nobody had trimmed them yet. It bothered them to have their nails so long.On 4/30/26 at 11:22 a.m., R8 was seated in wheelchair in room the nail clipper was still on the bedside table. R8 stated they know I want my nails trimmed but nobody has done it yet.During an interview on 4/29/26 at 2:14 p.m., licensed practical nurse (LPN-C) stated all residents should have nail care offered on shower day. Nursing assistants (NA) do nail care unless the resident is a diabetic or has some other considerations, then the nurse would do the nail care on bath day.During an interview on 4/29/26 at 1:29 p.m., NA-J stated typically we do nail care on bath days but if a resident wanted their nails trimmed either the NA or the nurse should do it.04/29/2026 1:39 p.m., NA-G 3 stated NAs could do nail care for R8. Activities did a spa day group so R8 could get their nails done in group, otherwise fingernails got done on bath days.04/29/2026 1:46 p.m., NA-B stated NAs could cut fingernails on most residents including R8. Every room also had an activities calendar. Residents can see when they can go to group and get their nails done by activities.During an interview on 4/30/26 at 11:41 a.m., registered nurse (RN-B) stated both nursing assistant and wellness staff (they are NAs) can trim nails. R8 can have either trim their nails. Regardless of what day it is, if a resident requests to have their nails trimmed, their nails should be trimmed. If the NAs can't do it, then they should get the nurse to do it.During an interview on 4/30/26 at 12:52 p.m., the director of nursing (DON) stated nail trimming was typically done on shower days, but if a resident was requesting to have their nails trimmed on a different day, she would expect staff to trim those nails. A resident should not have to wait until their next bath day to get their nails trimmed.The facility policy Resident Choice Policy & Procedure dated 5/2/26, identified autonomy and self-determination were fundamental to quality of life and dignity. The facility would provide a supportive environment that encouraged and facilitated resident choice, respected individual preferences and needs to the greatest extent possible consistent with safety and regulations.The undated facility policy Fingernails-Cleaning and Trimming provided instruction on how to complete nail care and instructed nursing staff will provide nail care as necessary to residents.