Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 26, 2026

Administrator
CLARA CITY CARE CENTER
1012 NORTH DIVISION STREET
CLARA CITY, MN 56222

RE: CCN: 245573
Cycle Start Date: April 1, 20-26

Dear Administrator:

On May 1, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 9, 2026

Administrator
CLARA CITY CARE CENTER
1012 NORTH DIVISION STREET
CLARA CITY, MN 56222

RE: CCN:245573
Cycle Start Date: April 1, 2026

Dear Administrator:

On April 1, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 1, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 1, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245573	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET , CLARA CITY, Minnesota, 56222

(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
E0000	Initial Comments On 3/30/26 to 4/1/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 3/30/26 to 4/1/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55737261C (iQIES # 2590807). NO deficiencies were cited. The following complaints were reviewed: H55737262C (iQIES #1170152) NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0628 SS = A	Discharge Process	F0628		

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 reverse for further 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.

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

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F0628 SS = A	Continued from page 1 CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F0628		

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F0628 SS = A	Continued from page 2 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone	F0628		

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F0628 SS = A	Continued from page 3 number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

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F0628 SS = A	Continued from page 4 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the resident or legal representative had been provided a written notice of transfer for 1 of 1 residents (R32) reviewed for hospitalization. Findings Include: R32's admission Minimum Data Set dated 2/6/26, identified R32 had moderate cognitive impairment with diagnoses which included: hemiplegia (one sided paralysis or weakness) following cerebral infarction (type of stroke) depression and aphasia	F0628		

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F0628 SS = A	Continued from page 5 (impaired ability to comprehend or produce language). R32 received speech therapy, occupational therapy and physical therapy. R32 was dependent on staff for bathing, dressing, toileting, and transfers. Review or R32's progress notes included the following:-2/6/26 at 5:20 p.m., - R32 admitted from hospital with a cerebral vascular accident (CVA) with right side hemiparesis (one side weakness or inability to move one side of body after a stroke). -3/3/26 at 5:26 p.m., R32 transferred to hospital, family member updated, and verbal permission given to hold bed. -3/12/26 at 8:32 p.m., family member no longer wanted to hold bed for R32, so R32 was discharged from facility. R32's medical record lacked documentation that a written transfer notification was provided to the resident and/or resident's representative. During interview on 4/1/26 at 7:55 a.m., registered nurse (RN)-A confirmed R32 had been transferred to the hospital. RN-A stated she was unaware a written notification for transfer was necessary, and indicated licensed social worker (LSW)-A may have completed one. During interview on 4/1/26 at 8:42 a.m., LSW-A verified she notified the ombudsman monthly for all transfers and discharges completed the previous month. LSW-A stated her usual process was to send a list of residents who discharged and were transfered. LSW-A confirmed she had not completed a written notification of transfer to R32 or R32's representative, which then would be sent to the ombudsman. LSW-A indicated was not aware that needed to be completed. During interview on 4/1/26 at 9:09 a.m., director of nursing (DON) verified R32 had been transferred to the hospital and family member was informed verbally of the reason for R32's transfer. DON indicated the facility did not complete written notification of transfer to be given to the resident or representative, then sent to ombudsman. DON stated was unaware that was necessary. The facility policy titled Hospital Transfer Policy And Procedure, undated, included the following: call family and make sure they were ok with hospital transfer and confirm bed hold. The policy lacked instructions to complete a written notification of hospital transfer to be provided to residents and/or resident representatives. The policy also lacked instructions to send the written notification to the ombudsman.	F0628		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	1) Actions immediately taken to correct were to dispose of all expired and undated food items including opened food items past the seven-day limit. 2) All residents have potential to be affected by this deficient practice; the corrective action noted above has mitigated risk for all residents. Additionally, a	04/17/2026

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F0812 SS = F	Continued from page 6 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure refrigerated food items were properly labeled, dated, and closed after the packaging was opened to prevent cross contamination which had the potential to affect all 28 residents currently residing in the facility. In addition, the facility failed to ensure refrigerated food items were disposed of after the expiration date or opened per facility policy. Findings Include:During the initial tour of the main kitchen on 3/30/26 at 12:36 p.m., with the dietary manager (DM)-A, the following areas of concern were identified and confirmed by DM-A: Upright refrigerator: -small disposable covered container of cake dated 3/5/26. -plastic half bag of salami slices, opened, undated. Walk In refrigerator: -opened gallon plastic container of ranch dressing, undated, expiration date of 9/25/25. -opened container of thousand island dressing, undated, expiration date 3/21/26.During a follow up interview on 3/31/26 at 1:33 p.m., DM-A stated most items that were opened should be	F0812	Continued from page 6 thorough inspection of all food storage areas, both dry storage and refrigeration, was completed to verify all outdated and undated items were disposed of, and to ensure that all opened items were properly dated and were not past the seven-day limit. 3) Cook or designee has been assigned the weekly task of inspecting all food storage areas. They will dispose of items that are expired or due to expire, and/or that have not been dated after opening. Re-educated all culinary staff on safe food handling regarding expired or undated food items, and that it is everybody’s responsibility to ensure we are not serving expired and potentially unsafe food. 4) The Culinary Services Manager or designee will conduct weekly audits x 4 weeks, then monthly as part of routine safe food handling duties. Results will be reported at the Quarterly QAPI team meeting. Corrective action recommendations will be made and monitored as warranted.	

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F0812 SS = F	Continued from page 7 disposed of after seven days. DM-A confirmed her expectation would be condiments would be disposed of after expiration date. DM-A indicated foods should be dated when opened, so staff knew how old an item was, and then disposed of per facility policy for food safety. The facility policy titled Food Storage dated 2021, identified food would be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. The policy identified leftover foods would be clearly labeled and dated and used within seven days or discarded. Refridgerator foods should be covered, labeled, dated, and routinely monitored to assure foods would be consumed by their safe use by dates, frozen, or discarded.	F0812		

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CLARA CITY CARE CENTER	1012 NORTH DIVISION STREET , CLARA CITY, Minnesota, 56222

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/31/2026. At the time of this survey, Clara City Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:	K0000		04/24/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/31/2026

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K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Clara City Care Center is a 1-story building with a partial basement. The building was constructed at five different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1970, an addition was constructed and was determined to be of Type II(111) construction. In 1989, an addition was constructed and was determined to be of Type II (111) construction. The 1997 addition was constructed and was determined to be of Type II(111) construction. The facility added a new kitchen addition in 2010 constructed of type II(111) construction. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0345 SS = C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K0345	Per NFPA 72 (2010 edition), National Fire Alarm and Signaling Code our newly installed system (9/2020) was tested with smoke detector sensitivity on 9/16/2020, and the second required test with smoke detector sensitivity was completed one year later on 9/23/2021. After these two successful tests, the test cycle with smoke detector sensitivity requirement is every five years. The required 5-year test with smoke detector sensitivity is scheduled for 9/2026.	04/24/2026

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K0345 SS = C	Continued from page 2 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the smoke detection system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3.2. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 03/31/2026 at 10:49 AM, it was revealed by a review of available documentation that the smoke detector sensitivity report did not indicate the measured setting of each smoke detector in the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345	Continued from page 2 The facility Maintenance Director is responsible for tracking compliance with life safety requirements. The Administrator or designee will audit records of NFPA 101 Life Safety Code and NFPA 72 National Fire Alarm and Signaling Code for required testing and documentation of measured setting of smoke detectors with each annual review of the facility's Emergency Preparedness Program. The results will be documented and reported to the QAPI team. Date of completion 4/24/2026	
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility	K0353	The corrective action taken was to remove the items and to inspect all storage areas for items too close to sprinkler heads. All sprinkler heads were inspected and dusted as needed. Leadership team and facility staff re-educated on Code requirements regarding storage and sprinkler head clearance and free of dust and debris. To ensure the deficiency does not re-occur, facility Maintenance Director will conduct a quarterly inspection of all storage areas for items too close to sprinkler heads and that sprinkler heads are free of dust and debris. The results of inspections will be documented and reported to the QAPI team. Date of completion 4/24/2026	04/24/2026

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K0353 SS = E	Continued from page 3 failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(5), and 5.2.1.2. These deficient findings could have a patterned impact on residents within the facility. Findings include:On 03/31/2026 at 11:37 AM, it was revealed by observation that items on the top shelf of a storage closet in Caring Place by the nurse's station were too close to the sprinkler head.On 03/31/2026 at 11:44 AM, it was revealed by observation the sprinkler head near the air vent in Room 84 was covered in dust and lint.An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0353		
K0374 SS = D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, and 8.5.4.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/31/2026 at 11:56 AM, it was revealed by observation that the smoke barrier doors for Maple Hall did not close completely leaving a gap between the doors when released from the magnetic hold-open device.	K0374	The door was cleaned to remove debris which was interfering with door function. The doors were tested; they are functioning as required. The facility Maintenance Director or designee will inspect door function with each fire system and evacuation drill. The result of the inspection will be reported to the QAPI team. Date of completion 4/17/2026	04/17/2026

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K0374 SS = D	Continued from page 4 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0374		
K0918 SS = C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the essential electric systems per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1, and 8.3.4.1. This deficient finding could have a widespread impact on residents within the facility. Findings include:	K0918	At the time of the MDH annual inspection, the facility Maintenance Director was unable to locate the December of 2025 generator inspections documentation. The required generator inspections documentation for December of 2025 was subsequently located and filed in the correct binder. See attached. Date of completion 4/13/2026	04/13/2026

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K0918 SS = C	Continued from page 5 On 03/31/2026 at 11:03 AM, it was revealed by a review of available documentation that weekly generator inspections were not documented during December of 2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly use extension cords per NFPA 70 (2011 edition), National Electrical Code, section 400.8(1). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/31/2026 at 12:08 PM, it was revealed by observation that a tan extension cord was being used to provide power to a recumbent exercise machine in the Rehab Area. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0920	The tan extension cord to the recumbent exercise machine in the Rehab Area was immediately removed. The recumbent exercise machine was relocated to an area where it could be plugged directly into an outlet. An inspection of all facility rooms was conducted to determine if there were more instances of extension cords in use. Corrective action was taken as needed. All staff re-educated on the Code related to electrical equipment and power/extension cords, and to immediately report any are observed in use. This function will be included in the PCREE program. The facility maintenance director or designee will conduct monthly audits x 3 months, then every 6 months with results reported to the QAPI team. Date of completion 4/24/2026	04/24/2026