Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 17, 2025

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

RE: CCN: 245573
Cycle Start Date: October 23, 2025

Dear Administrator:

On October 30, 2025, we notified you a remedy was imposed. On "November 13, 2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 12, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 14, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of October 30, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 23, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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

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Administrator
CLARA CITY CARE CENTER
1012 NORTH DIVISION STREET
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Re: Reinspection Results
Event ID: 1D996D-H1

Dear Administrator:

On November 13, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 23, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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Federal Enforcement | Health Regulation Division
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Saint Paul, MN 55164-0900
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An equal opportunity employer.

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2025

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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/21/25-10/23/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		10/31/2025

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 The following complaints were reviewed: H55735807C (2642065) with a licensing order issued at 4658.0405 Subp 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for	20555	Corrected	11/12/2025

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20555	Continued from page 2	20555		

the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.

This LICENSURE REQUIREMENT is NOT MET as evidenced by:

Based on document review and interviews, the facility failed to develop and implement comprehensive care plans for 2 of 3 residents (R1, R2) reviewed for elopement.

Findings include:

R1 was admitted to the facility on 9/11/25. R1’s face sheet dated 10/22/25, indicated diagnoses of dementia, depression, and anxiety.

R1’s admission Minimum Data Set (MDS) dated 9/18/25, identified R1 had mild cognitive impairment and required staff assistance for activities of daily living with transfers and ambulation. R1 used a wheelchair for locomotion.

R1’s elopement risk assessment dated 9/11/25, identified at risk for elopement related to resident being independent in wheelchair locomotion, cognitive impairment and making statements that he was leaving. R1 was at risk for elopement.

R1’s care plan dated 9/26/25, identified an elopement problem. The care plan indicated R1 was a t risk for elopement related to making statement of leaving to go home. The goal was for R1 to not elope from the facility during the next 90 days. The only intervention was a Wander Guard on R1’s ankle; the care plan did not identify individualized interventions to manage R1's elopement risk and/or statements of leaving the facility.

R1’s progress note dated 10/2/25, at 3:41 p.m., indicated R1 had exit seeking behaviors when he put on his coat, went towards an exit and stated he was going home. There was no indication R1’s care plan was reviewed/revised after R1 demonstrated exit seeking behaviors.

R1’s progress note dated 10/13/25 at 3:45 a.m., identified registered nurse (RN)-A received a call from a passerby that they had a resident. No injuries identified during the skin assessment. R1 was put back to bed, safety checks were implemented. RN-A assessed all doors in the facility besides the

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20555	Continued from page 3	20555		

emergency only doors in the unused part of the building.

R2

R2 was admitted to the facility on 9/27/24. R2's face sheet dated 10/21/25, indicated diagnoses of hemiplegia (partial paralysis) following cerebral infarction (stroke), cognitive deficit following other cerebrovascular disease, insomnia, anxiety and unspecified symptoms involving cognitive functions and awareness.

R2's annual MDS assessment dated 9/5/25 indicated R2 was cognitively intact and required moderate assistance for activities of daily living.

R2's elopement evaluation dated 6/9/25 indicated R2 was independent in locomotion, had cognitive impairment and had displayed behavior that may indicate an attempt to leave and that an elopement may be forthcoming. R2 was at risk for elopement.

R2's care plan dated 10/21/25, listed a problem with safety and falls. An approach listed for the fall risk was "Wander Guard to wheelchair handle." The care plan did not have a focus area related to elopement and did not have any individualized interventions for exit seeking behavior.

On 10/21/25 at 3:07 p.m., registered nurse (RN)-A was interviewed and stated on 10/13/25 at approximately 11:00 pm., R1 came over and asked for the sign out book, had all of his belongings with him and said he was leaving. RN-A stated she did not do anything such as increasing supervision or trying elopement interventions because she was busy with another resident. RN-A verified staff had radios to communicate with each other. RN-A did not communicate with the nursing assistants to increase supervision or try elopement interventions.

On 10/22/25 at 12:20 p.m.., the director of nursing (DON) was interviewed and stated R1's care plan had not been updated yet to include individualized interventions for his exit seeking behavior and it was not part of the remaining follow up after the elopement event.

On 10/22/25 at 12:30 p.m., trained medical assistant (TMA)-A, was interviewed and stated that the care plan should indicate if a resident is at risk for elopement.

On 10/22/25 at 12:45 p.m., RN-B was interviewed and

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20555	Continued from page 4 stated residents who are elopement risks have a section about safety and falls in their care plans. There are interventions staff are doing that is not documented in the care plans when residents had been exit seeking. RN-B said those interventions could be added to the care plans. On 10/22/25 at 1:30 p.m., nursing assistant (NA)-B was interviewed, and was able to list interventions for each resident with exit seeking behaviors but was unsure where those interventions were documented. The facility policy, Resident MDS and Care Planning, last modified on 1/13/21 directs that all residents will have a comprehensive assessment completed upon admission, annually and with a significant change. Risk factors and assessment to be competed by a nurse on an admission, quarterly and PRN and includes elopement. Suggested Method of Correction: the DON/designee could review/revise the policy, educate staff on the policy, review resident care plans for appropriateness, and then develop an auditing system to maintain compliance. Time period of correction: twenty-one (21) days	20555		

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F0000	INITIAL COMMENTS On 10/21/25-10/23/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 10/13/25, when staff failed to identify doors were not secured and failed to develop and implement appropriate interventions when R1 displayed exit seeking behaviors and left the building unwitnessed. The administrator, and director of nursing (DON) were notified of the IJ on 10/22/25 at 3:05 p.m. The IJ was removed on 10/23/25 at 4:15 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 10/23/25. The following complaints were reviewed: H55735807C (2642065) with a deficiency cited at F689, F656. 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 that substantial compliance with the regulations has been attained.	F0000		10/31/2025
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes	F0656	Resident 1, and Resident 2's care plans were reviewed and updated to include individualized interventions when exit seeking behavior is noted. Care plans will be reviewed and updated by the Charge Nurse immediately upon noting exit seeking behavior. All residents at risk for elopement, including those who exhibit exit seeking behavior have the potential to be affected by this deficient practice.	11/12/2025

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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F0656 SS = D	Continued from page 1 measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and implement comprehensive care plans for 2 of 3 residents (R1, R2) reviewed for elopement. Findings include:	F0656	Continued from page 1 The Clara City Care Center has evaluated, developed and implemented individualized interventions for residents who are observed as exit seeking. Director of Nursing or designee has educated nurses immediately or prior to their next scheduled shift who will be responsible for the revision of the care plan to input intervention into the care plan immediately and how to determine appropriate increased supervision levels. This was completed with a handout and knowledge check on 10/23/25. Director of Nursing or designee will educate all staff nurses immediately or prior to their next scheduled shift on exit seeking behaviors, intervention appropriate for redirection or increased supervision, when to notify and communicate with other staff about an elopement. If a non-facility staff is involved in the event, staff will obtain contact name, phone number and information about the resident related to the event such as location, what resident was doing and the residents mental status. This was completed with a handout and knowledge check on 10/23/25. Director of Nursing or designee will audit care plans of residents at risk of elopement to ensure individualized intervention are in place for exit seeking behavior and other elopement risks. The audits will be completed weekly x 4 weeks and monthly x5 months Results of these audits will be reported monthly to the QAPI Committee for review and further action if necessary.	

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F0656 SS = D	Continued from page 2 R1 was admitted to the facility on 9/11/25. R1's face sheet dated 10/22/25, indicated diagnoses of dementia, depression, and anxiety. R1's admission Minimum Data Set (MDS) dated 9/18/25, identified R1 had mild cognitive impairment and required staff assistance for activities of daily living with transfers and ambulation. R1 used a wheelchair for locomotion. R1's elopement risk assessment dated 9/11/25, identified at risk for elopement related to resident being independent in wheelchair locomotion, cognitive impairment and making statements that he was leaving. R1 was at risk for elopement. R1's care plan dated 9/26/25, identified an elopement problem. The care plan indicated R1 was a t risk for elopement related to making statement of leaving to go home. The goal was for R1 to not elope from the facility during the next 90 days. The only intervention was a Wander Guard on R1's ankle; the care plan did not identify individualized interventions to manage R1's elopement risk and/or statements of leaving the facility. R1's progress note dated 10/2/25, at 3:41 p.m., indicated R1 had exit seeking behaviors when he put on his coat, went towards an exit and stated he was going home. There was no indication R1's care plan was reviewed/revised after R1 demonstrated exit seeking behaviors. R1's progress note dated 10/13/25 at 3:45 a.m., identified registered nurse (RN)-A received a call from a passerby that they had a resident. No injuries identified during the skin assessment. R1 was put back to bed, safety checks were implemented. RN-A assessed all doors in the facility besides the emergency only doors in the unused part of the building. R2 R2 was admitted to the facility on 9/27/24. R2's face sheet dated 10/21/25, indicated diagnoses of hemiplegia (partial paralysis) following cerebral infarction (stroke), cognitive deficit following other cerebrovascular disease, insomnia, anxiety and unspecified symptoms involving cognitive functions and awareness. R2's annual MDS assessment dated 9/5/25 indicated R2 was cognitively intact and required moderate assistance	F0656		

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F0656 SS = D	Continued from page 3 for activities of daily living. R2's elopement evaluation dated 6/9/25 indicated R2 was independent in locomotion, had cognitive impairment and had displayed behavior that may indicate an attempt to leave and that an elopement may be forthcoming. R2 was at risk for elopement. R2's care plan dated 10/21/25, listed a problem with safety and falls. An approach listed for the fall risk was "Wander Guard to wheelchair handle." The care plan did not have a focus area related to elopement and did not have any individualized interventions for exit seeking behavior. On 10/21/25 at 3:07 p.m., registered nurse (RN)-A was interviewed and stated on 10/13/25 at approximately 11:00 pm., R1 came over and asked for the sign out book, had all of his belongings with him and said he was leaving. RN-A stated she did not do anything such as increasing supervision or trying elopement interventions because she was busy with another resident. RN-A verified staff had radios to communicate with each other. RN-A did not communicate with the nursing assistants to increase supervision or try elopement interventions. On 10/22/25 at 12:20 p.m.., the director of nursing (DON) was interviewed and stated R1's care plan had not been updated yet to include individualized interventions for his exit seeking behavior and it was not part of the remaining follow up after the elopement event. On 10/22/25 at 12:30 p.m., trained medical assistant (TMA)-A, was interviewed and stated that the care plan should indicate if a resident is at risk for elopement. On 10/22/25 at 12:45 p.m., RN-B was interviewed and stated residents who are elopement risks have a section about safety and falls in their care plans. There are interventions staff are doing that is not documented in the care plans when residents had been exit seeking. RN-B said those interventions could be added to the care plans. On 10/22/25 at 1:30 p.m., nursing assistant (NA)-B was interviewed, and was able to list interventions for each resident with exit seeking behaviors but was unsure where those interventions were documented. The facility policy, Resident MDS and Care Planning, last modified on 1/13/21 directs that all residents will have a comprehensive assessment completed upon	F0656		

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F0656 SS = D	Continued from page 4 admission, annually and with a significant change. Risk factors and assessment to be competed by a nurse on an admission, quarterly and PRN and includes elopement.	F0656		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure doors were secured and failed to implement individualized interventions to prevent/reduce the risk of elopement for 1 of 3 residents (R1) who had a history of exit seeking behaviors. This resulted in an immediate jeopardy (IJ) when R1 eloped from the facility through two unsecured doors and the wander guard alarm did not work. R1 was later found and returned to the facility by a passerby. The IJ began on 10/13/25, when staff failed to identify doors were not secured and failed to develop and implement appropriate interventions when R1 displayed exit seeking behaviors and left the building unwitnessed. The director of nursing (DON) was notified of the IJ on 10/22/25 at 3:05 p.m. The IJ was removed on 10/23/25 at 4:15 p.m., when the facility implemented immediate corrective action to prevent recurrence, but noncompliance remained at a lower scope and severity of D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1 was admitted to the facility on 9/11/25. R1's face sheet dated 10/22/25, indicated diagnoses of dementia, depression, and anxiety. R1's admission Minimum Data Set (MDS) dated 9/18/25, identified R1 had mild cognitive impairment and required staff assistance for activities of daily living with transfers and ambulation. R1 used a wheelchair for locomotion. R1 did not have behaviors or range of motion limitations. R1's elopement risk assessment dated 9/11/25, identified at risk for elopement related to resident being independent in	F0689	The Clara City Care Center has identified all staff that have a key to the locked door involved in this incident and when staff might use the key to unlock that door. The Clara City Care Center has developed and implemented a system where audits are being completed to ensure all exit doors are secure. The Clara City Care Center developed a door lock check system to specifically address the two doors involved with the elopement are locked at all times of the day, not just on the night shift. These doors will be checked every shift by the licensed staff who will document on paper form the status of the door and lock if unlocked. All licensed staff who are responsible for this audit have been educated via hand out and knowledge check. Resident 1's care plan has been updated to include individualized interventions to prevent or reduce the risk of elopement including adding interventions for exit seeking behavior. All residents at risk for elopement, including those who exhibit exit seeking behavior have the potential to be affected by this deficient practice. The Clara City Care Center has reviewed the policy and procedure on a missing resident (Elopement policy), and no changes were made. The Clara City Care Center has evaluated, developed and implemented individualized interventions for residents who are observed as exit seeking. Director of Nursing or designee has educated nurses immediately or prior to their next scheduled shift who will be responsible for the revision of the care plan to input intervention into the care plan immediately and how to determine appropriate increased supervision levels. This was completed with a handout and knowledge check on 10/23/25. Director of Nursing or designee will educate all staff nurses immediately or prior to their next scheduled shift on exit seeking behaviors, intervention appropriate for redirection or increased supervision, when to notify and communicate with other staff about an elopement. If a non-facility staff is involved in the event, staff will obtain contact name, phone number and information about the resident related to the event	11/12/2025

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 10/23/2025

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
F0689 SS = SQC-J	Continued from page 5 wheelchair locomotion, cognitive impairment and making statements that he was leaving. R1’s care plan dated 9/26/25, identified an elopement problem. The care plan indicated R1 was a t risk for elopement related to making statements of leaving to go home. The goal was for R1 to not elope from the facility during the next 90 days. The only intervention was a Wander Guard on R1’s ankle. The care plan also identified R1 as a fall risk. R1's progress note dated 10/2/25, at /3:41 p.m., /indicated R1 had exit seeking behaviors when he put on his coat, went towards an exit and stated he was going home. There was no indication R1’s care plan was reviewed/revised after R1 demonstrated exit seeking behaviors (Documentation for subsequent care planning or new interventions following this incident was requested but not received.) R1’s progress note dated 10/7/25, indicated R1 had an unwitnessed fall with no injuries. R1’s progress note dated 10/13/25 at 3:45 a.m., /identified registered nurse (RN)-A received a call from a passerby that they had a resident (R1). No injuries identified during the skin assessment. R1 was put back to bed, safety checks were implemented. RN-A assessed all doors in the facility besides the emergency only doors in the unused part of the building. On 10/13/25 at 11 p.m., the temperature in Clara City was 49 degrees Fahrenheit per Localconditions.com The nursing home is located on the corner of Division Street (one of the main roads in town) and 40th street where curbs buffer the street right outside the facility. The east side of the building is next to corn fields. There is an operating railroad approximately one mile south of the facility. The State Agency 5-day report dated 10/16/25, included nursing assistant (NA)-A's interview. The report indicated on the evening of 10/13/25 at around 11:00 p.m. R1 asked NA-A to help tie his bag with his belongings. NA-A asked if he was leaving and R1 said yes. NA-A said ok and went to the nursing station. Approximately 5 minutes later, R1 came to the nurse's station and asked how to sign out. NA-A told R1 to go talk to the nurse about it. On 10/21/25 at 12:04 p.m., a call was placed to nursing assistant (NA)-A however it was not answered, there was no return call. During an interview on 10/21/25 at 3:07 p.m., RN-A indicated the evening of 10/13/25, R1 asked her about the sign out book and stated he was leaving. RN-A told R1 it is the middle of the night, and no one is coming to pick you up. R1 turned around and wheeled himself to the other end of the building. RN-A did not communicate to NA’s R1 was exit seeking nor increased supervision and/or changed the care plan. RN-A was not aware R1 had exited the building until the passerby called the facility; she did not get any specific information from the passerby such as exact location where R1 was found	F0689	Continued from page 5 such as location, what resident was doing and the residents mental status. This was completed with a handout and knowledge check on 10/23/25. The Clara City Care Center currently uses agency staff. Material on audits, elopement policy and care plan revision were added to their orientation checklist. Director of Nursing or designee will review paper documentation of Door Check Process weekly x4 weeks, and monthly x5 months. Results of these audits will be reported monthly to the QAPI Committee for review and further action if necessary. Director of Nursing or designee will audit care plans of residents at risk of elopement to ensure individualized intervention are in place for exit seeking behavior and other elopement risks. The audits will be completed weekly x 4 weeks and monthly x5 months Results of these audits will be reported monthly to the QAPI Committee for review and further action if necessary.	

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 **10/23/2025**

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

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F0689 SS = SQC-J	Continued from page 6 and R1’s mental status. RN-A indicated she had seen R1 approximately 30 minutes prior to the call when he had asked to leave; R1 had been wearing a sweatshirt, sweatpants, and tennis shoes. RN-A was not aware that the exit doors that were supposed to be locked were unlocked at the time R1 left the facility because she had not checked them. RN-A stated she implemented every 2-hour checks, however, was unable to articulate how she determined every two hours was appropriate or individualized. During an interview on 10/21/25 at 2:08 p.m., social worker (SW) stated R1 was able to show her which hallway he went down and which doors he exited the facility from. He recognized duct work in between the two exit doors. Outside, R1 told the social worker he recognized the curb that he went down in his wheelchair. During an interview on 10/22/25 at 8:22 a.m., maintenance manager (MM) indicated R1 exited through two unsecured unlocked doors that were supposed to be locked. The Wander Guard system on the last door was not functioning properly. It was a known issue that the Wander Guard on that door does not beep, it was discussed at department head meetings several times. MM indicated there previously was not a system in place to ensure the exit doors were always locked. After the incident MM inspected all the doors and only found that the doors were unlocked not that there were mechanical issues. During an interview on 10/22/25 at 9:19 a.m., DON reviewed R1’s record, she explained there was no interventions put into place after R1 demonstrated exit seeking behaviors on 10/2/25. The evening of 10/13/25, after RN-A became aware of the exit seeking behavior there was a lack of communication between staff and no immediate interventions were implemented to prevent/mitigate R1’s risk for elopement. After R1 eloped on 10/13/25, immediate interventions of two-hour checks were implemented, but no other individualized interventions were implemented that addressed R1’s exit seeking behavior. DON stated prior to the elopement there was not a system in place to assure all the doors in the facility were secured. After the elopement and prior to survey entrance on 10/21/25, every-two hour safety checks were changed to every one hour, a bed alarm as placed on R1’s bed, and a system to check the doors only during the evening was implemented. Additionally, staff had received education on elopement procedures and checking locked doors however, indicated staff were not educated on developing interventions, revision of the care plan, and implementing interventions that addressed exit seeking behaviors was not addressed. During an interview at 10/22/25 at 12:30 p.m., trained medication aide (TMA)-A stated he had received training on the elopement procedure but exit seeking interventions was not addressed. He stated care plans should include elopement risks and	F0689		

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F0689 SS = SQC-J	Continued from page 7 interventions. During an interview at 10/22/25 at 1:30 p.m., NA-B stated she had education on the elopement procedure but there was no mention of interventions for exit seeking behavior. The facility policy Missing Resident/Elopement Policy and Procedure last revised 10/14/25 directed that after an elopement, the charge nurse will update the resident's assessment and care plan as needed. The charge nurse will orient staff to any new interventions or procedures to reduce the risk of future problems for this or other residents. The IJ was removed on 10/23/25 at 4:15 p.m., when it was verified the facility implemented the following corrective actions: *The facility provided education with knowledge checks to all nursing staff on revising care plans for individualized, immediate interventions for exit seeking behaviors. *The facility provided education with knowledge checks to all staff on identifying exit seeking behaviors, implementing appropriate interventions for redirection and increased supervision. When to notify and communicate with other staff about elopement risk concerns. When to ask passerby citizens about an elopement, such as where the resident was found, what the resident was doing and what their mental status was. *Identified staff who have a key to the locked door. *Developed a door lock check system that assures the two doors involved with the elopement are locked. The doors are checked at least once per shift by nursing staff and documented in a sign off sheet. *Reviewed the elopement policy and procedure. Educated staff on the elopement policy and procedure.	F0689		