



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 23, 2026

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

RE: CCN: 245573

Cycle Start Date: December 4, 2025

Dear Administrator:

On December 17, 2025, we notified you a remedy was imposed. On January 15, 2026, 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 January 14, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 1, 2026, be discontinued as of January 14, 2026. (42 CFR 488.417 (b))

In our letter of December 17, 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 January 1, 2026. 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,

A handwritten signature in cursive script that reads '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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December 17, 2025

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

RE: CCN: 245573

Cycle Start Date: December 4, 2025

Dear Administrator:

On December 4, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 1, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 1, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 1, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance, or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 1, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Clara City Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 1, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "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

An equal opportunity employer.



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December 17, 2025

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

Re: Event ID: 1DCFAB-H1

Dear Administrator:

The above facility survey was completed on December 04, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads '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 12/04/2025
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NAME OF PROVIDER OR SUPPLIER CLARA CITY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 NORTH DIVISION STREET , CLARA CITY, Minnesota, 56222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F0000	<p>INITIAL COMMENTS</p> <p>On 12/3/25 - 12/4/25 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed. H55738122C / MN2671008 with a deficiency issued at F689</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F0000		12/17/2025
F0689 SS = G	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review the facility failed to adequately supervise a resident to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents and supervision. R1 had a chair alarm that</p>	F0689	<p>Resident 1 was assessed for continued fall risk on her return from the hospital had hourly checks added to her care plan to further mitigate her risk of falling.</p> <p>All residents at risk of falls have the potential to be affected by this deficient practice.</p> <p>Fall Prevention and Management policy was reviewed and updated to include specific use of motion alarms and specific definitions of adequate supervision, assessments, and interventions.</p> <p>DON or designee will reeducate staff on Fall Prevention with specific focus on Adequate Supervision and individualized interventions to mitigate fall risk, with knowledge check to confirm understanding.</p> <p>DON or designee will audit care plans for adequate supervision and individualized interventions monthly x6 and report to QAPI Committee for review and change as needed.</p>	01/14/2026

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
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F0689 SS = G	<p>Continued from page 1 would sound when R1 would stand. The chair alarm prompted staff to respond to R1 after standing. R1 was found on her bathroom floor, transferred to the hospital with a left hip fracture.</p> <p>Findings include:</p> <p>According to the State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, Rev. 229, Issued: 04/25/25 supervision is an intervention and a means of mitigating accident risk. Facilities are obligated to provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Devices such as position change alarms may help to monitor a resident's movement temporarily, but do not eliminate the need for adequate supervision. Position change alarms are not prohibited from being included as part of a plan, they should not be the primary or sole intervention to prevent falls. If facility staff choose to implement alarms, they should document their use aimed at assisting the staff to assess patterns and routines of the resident. Use of these devices, like any care planning intervention, must be based on assessment of the resident and monitored for efficacy on an on-going basis. Position change alarms have been used to monitor a resident's movement in chairs or beds, etc. However, there must be sufficient staff and supervision to meet the resident's needs and staff must be vigilant in order to respond to alarms in a timely manner. Alarms do not replace necessary supervision. Facilities must take steps to identify issues that place the resident at risk for falls and implement approaches to address those risks in a manner that enables the resident to achieve or maintain their highest practicable physical, mental, and psychosocial well-being.</p> <p>R1's nursing order dated 3/29/24 at 2:26 p.m. indicated R1 had a fall alarm on her wheelchair and in her bed due to repeated falls. The order was open ended. The alarms were to be checked three times a day, a.m., p.m., and at the hour of sleep (HS).</p> <p>R1's care plan dated 4/2/24 indicated R1's problem was safety/falls indicating she was at risk for falls and injuries as evidenced by unsteady gait and balance,</p>	F0689		

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F0689 SS = G	<p>Continued from page 2 need for assistance to transfer on and off the toilet, recent emergency department visit, use of assistive devices, cognitive status, history of falls. R1 was taking Donepezil (for treatment of dementia), risperidone (anti-psychotic), and sertraline (anti-depressant). She had diagnoses of fracture of the fifth metatarsal bone of the left foot, generalized anxiety and imbalance. Interventions were:</p> <ul style="list-style-type: none"> · Wander guard to ankle to alert staff if she left the building · Adequate bed height · Adequate lighting · Call light in reach · Clear path to the bathroom · Clothing fits properly · Complete an incident report for any falls or injuries · Consult with registered nurse (RN) supervisor as needed · Electrical cords and call light cords in proper placement · Equipment in good repair · Floor clean and dry · Furniture in adequate placement · Hallways free of clutter · Notify family member and medical doctor (M.D.) if an incident report is completed · Proper non-slip footwear when not in bed · Report any confusion or light headedness to charge nurse · Report any indication of pain or unsteadiness to charge nurse · Room free of clutter · The following alarms were in place – bed and chair sensor alarm 	F0689		

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F0689 SS = G	<p>Continued from page 3</p> <ul style="list-style-type: none"> · Safety risk and physical device assessment quarterly and as needed (PRN) <p>R1's care plan failed to provide any interventions of staff supervisor for R1 to reduce the risk of falls.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 8/27/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 8 indicating R1 was cognitively impaired. R1's mobility devices used were a walker and a wheelchair. She required maximum assistance with toileting hygiene, showering, lower body dressing and walking. She required moderate assistance with upper body dressing, sitting to standing and transferring from chair to bed/bed to chair. R1 was frequently incontinent of urine and bowel. Her pertinent diagnoses were nondisplaced fracture of the fifth metatarsal bone left foot, open-angle glaucoma, age related osteoporosis. R1 used a bed alarm, chair alarm, and a wander/elopement alarm daily.</p> <p>R1's incident report dated 11/15/25 at 2:08 p.m. indicated R1 had a fall in the bathroom. The evaluation details indicated the root cause was R1 was a fall in her room due to the alarm on her chair was not turned on. R1 was transferred from the toilet in a different room. Staff flipped the alarm switch off when getting her to the toilet. A staff member was passing water and found R1 on the floor. The immediate intervention was R1 was sent to the emergency department (ED) due to hip pain. She was found to have a left femur fracture. The intervention on her hospital return was the sensor alarm was changed to one that automatically comes on. Staff education was completed to remind staff to make sure alarms are in place and on.</p> <p>R1's nursing progress note dated 11/15/25 indicated R1 was admitted to the hospital due to fall after staff found her between her wall and the bathroom door. 911 was called due to R1 stating that her help felt broken and was unable to move. R1 was diagnosed with a hip fracture.</p> <p>R1's nursing progress note dated 11/18/25 indicated R1 returned from the hospital following left hip fracture repair. R1 had three incision sites along the left lateral hip that were approximated with staples. The upper incision site had nine staples, the medial incision had five staples, and the lower incision site</p>	F0689		

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F0689 SS = G	<p>Continued from page 4 had three staples.</p> <p>R1's progress note dated 12/3/25 at 8:41 a.m. indicated R1 was in severe pain that morning and was sent via ambulance to the emergency department. She was admitted to the hospital. Therefore, R1 was not available for observations and interview during the survey process.</p> <p>Upon interview on 12/3/25 at 11:55 a.m. trained medication assistant (TMA)-A stated the staff was to make sure residents who have sensor alarms visualize that the alarms are in place under the wheelchair or in their bed. Anyone with a fall alarm should not be left alone in the bathroom and to make sure the alarm is always on except for when helping a resident with cares. She denied any staff supervision of residents with the alarms.</p> <p>Upon interview on 12/3/25 at 1:39 p.m. TMA-B stated on the day R1 fell she was found in an unoccupied resident's room attempting to toilet herself. He heard the alarm sound, found R1 and assisted her toilet. TMA-B stated he forgot to turn the alarm back on when he wheeled her into the commons area and left her there. An hour later nursing assistant (NA)-A was passing water and found R1 on the floor pushed against her bathroom door. R1 was found on the floor without her alarm sounding. The staff relies on the alarm to know if R1 had attempted to stand-up alone. He stated the alarm was the main intervention for residents with fall risks. He stated the process was if staff hear an alarm sound, they hear a number of which alarm was sounding (each resident has their own number with their personalized alarm). The staff then uses their walkie talkies to communicate with other staff to find the resident who was attempting to stand-up. TMA-B stated the staff catch a lot of residents before they actually fall with the alarms. He denied staff supervision for R1.</p> <p>Upon interview on 12/3/25 at 3:46 p.m. registered nurse, (RN)-A stated the facility tried to keep the residents with alarms in the lobby and staff check on all residents as they walk by their rooms. RN-A stated she was not certain what was meant by resident supervision interventions for residents at risk for falls.</p> <p>Upon interview on 12/4/25 at 11:48 a.m. NA-B stated</p>	F0689		

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F0689 SS = G	<p>Continued from page 5 there were not specific supervision interventions on the residents, but staff should always keep an eye on them. She stated R1 had a chair alarm and staff would find her all over the facility as she moved quickly in her wheelchair.</p> <p>Upon interview on 12/4/25 at 11:55 a.m. RN-B stated the facility used the motion sensor alarms to supervise the residents and many falls were avoided because of having the alarms. Unfortunately, R1's alarm was not turned on when she fell and broke her hip.</p> <p>Upon interview on 12/4/25 at 12:18 p.m. occupational therapist (OT)-A stated R1 was a very confused lady who wandered. R1 was fragile due to her age of 95, therefore it would be important to anticipate her needs and have eyes on supervision. She was not certain of the facilities interventions for R1.</p> <p>Upon interview on 12/4/25 at 12:51 p.m. the director of nursing (DON) stated all residents have interventions. Staff were to follow interventions on each resident's care plan. The residents have alarms for supervision. The DON was not aware that residents with safety alarms also required supervision defined by type and frequency of supervision as the alarms do not eliminate the need for adequate supervision.</p> <p>Multiple attempts were made to interview R1's family via phone, however calls were not returned.</p> <p>A facility policy titled Fall Prevention and Management Program dated 11/6/2019 indicated: The purpose of the falls prevention and management program is to develop, implement, monitor and evaluate an interdisciplinary team fall prevention approach and management strategies that foster resident independence and quality of life while ensuring safety of the resident and other residents and staff. The program focuses on reducing the incidence of resident's falls and mitigating risks of falls through a resident focused team approach which ensures that a resident's environment and social, physical, cognitive, and emotional strengths are supported. The program ensures team training, communication, and effective care planning. The facility will ensure that a fall interdisciplinary prevention and management program will be maintained to reduce the incidence of falls and the risk of injury to the resident and promote resident independence.</p>	F0689		

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER CLARA CITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 = G	Continued from page 6 A policy regarding safety alarms was requested however none provided.	F0689		

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER CLARA CITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 12/3/25 - 12/4/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed during the survey. H55738122C / MN2671008</p>	20000		12/17/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 12/04/2025
NAME OF PROVIDER OR SUPPLIER CLARA CITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		