Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 3, 2025

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

RE: CCN: 245573
Cycle Start Date: July 16, 2025

Dear Administrator:

On July 30, 2025, we notified you a remedy was imposed. On August 18, 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 08/13/2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective 08/14/2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 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 July 16, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 3, 2025

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

Re: Reinspection Results
Event ID: 4ZG612

Dear Administrator:

On 08/18/2025 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 07/16/2025. At this time these correction orders were found corrected.

Please feel free to call me with any 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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

July 30, 2025

Administrator

Clara City Care Center
1012 DIVISION STREET NORTH
Clara City, MN 56222

RE: CCN: 245573
Cycle Start Date: July 16, 2025

Dear Administrator:

On July 16, 2025, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) a pattern of deficiencies that constituted immediate jeopardy. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 16, 20225, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 July 16, 2025.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 16, 2025, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 16,2025, (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Clara City Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 16, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
The date that each deficiency will be corrected.
An electronic acknowledgement signature and date by an official facility representative.

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 "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 16, 2026, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to

an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

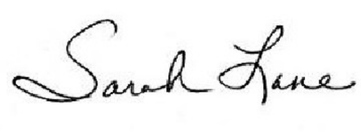
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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,



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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 30, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 4ZG611

Dear Administrator:

The above facility was surveyed on July 16, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

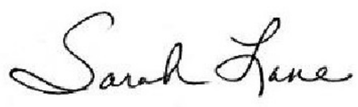
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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 07/16/2025

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
F0000	INITIAL COMMENTS On 7/14/25, 7/15/25, and 7/16/25, 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 F689 began on 7/9/25, when staff failed to ensure lift sling was properly secured prior to the transfer causing R1 to fall from the mechanical lift. The administrator, and director of nursing (DON) were notified of the IJ on 7/15/25 at 4:20 p.m. The IJ was removed on 7/16/25 at 2:11 p.m.. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 7/16/25. The following complaints were reviewed: H55739207C (MN00114530 and MN00114508) with a deficiency cited at F689. 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		08/13/2025
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	F0689	Resident 1 is consistently being transferred safely with a mechanical lift per the manufacturer's recommendations. A system was put into place to ensure resident 1, 2,3,5,6,8,9,10,11 who require mechanical lifts have completed comprehensive assessments for sling size and care plans developed reflecting use of mechanical lifts and sling size to be used. All residents who require a mechanical lift for transfers have the potential to be affected by this deficient practice.	08/13/2025

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

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 07/16/2025

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 1 §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, observation and document review, the facility failed to ensure safe use of a mechanical lift per manufacturer's recommendations to transfer 1 of 11 residents (R1), who required a mechanical lift for transfers. This resulted in an immediate jeopardy (IJ) when R1 fell from a full body mechanical lift causing R1 to suffer fractures to her cervical spine (C1 and C6), nasal cavity, and left femur as well as lacerations to facial area requiring hospital admission. In addition, the facility failed to ensure a system for completed comprehensive assessments for sling size and/or care plan development for 9 of 11 residents (R1, R2, R3, R5, R6, R8, R9, R10, R11) reviewed who required mechanical lifts. The IJ began on 7/9/25, when staff failed to ensure the lift sling was properly secured and the environment was clear prior to the transfer causing R1 to fall from the mechanical lift. The administrator and director of nursing (DON) were notified of the IJ on 7/15/25 at 4:20 p.m. The IJ was removed on 7/16/25 at 2:11 p.m., when the facility had implemented immediate corrective action to prevent recurrence, but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: A Facility Reported Incident (FRI) submitted to the State Agency (SA) on 7/9/25 at 9:25 a.m., alleged potential caregiver neglect when R1 fell from the mechanical lift during a transfer and sustained a large gash above right eyebrow and on her nose. R1 was transferred by ambulance to the emergency department (ED). R1's Emergency Department Note dated 7/9/25 at 7:49 a.m., identified R1 was seen in the ED for assessment after she fell out of a hoyer lift. R1 presented with laceration to right eyebrow, bridge of nose, and some bleeding to the gums of her mouth. R1 also complained of increased difficulty breathing through her nose as well as feeling her head was "heavy". The note	F0689	Continued from page 1 The facility policy and procedure for safe mechanical lift transfers was updated to include the appropriate mechanical lift company's manufacturer's recommendations and specific time out procedures to do safety checks to ensure all loops were hooked on the appropriate hook before lifting the resident and completing an environmental scan of all the area for possible obstacles prior to beginning the lifting procedure. Facility staff developed and implemented a system for an RN to comprehensively assess sling and belt sizes for individual residents who need a mechanical lift for transfers on admission and with significant change utilizing the full body and sit to stand mechanical lifts by utilizing the manufacturer's guidelines and nursing judgement. Sling and belt sizes for each resident were added to the resident's care plans and the NA care sheets (focus sheets). The facility provided education with return demonstration to all nursing staff on manufacturer's recommendations to include a safety check, doing an environmental scan, and using proper sling sizes for the residents. DON or designee will audit system for comprehensive assessment and designation of sling sizing and care planning for affected residents monthly x 6 months. Additionally, DON or designee will audit proper transfers on manufacturer's recommendations to include a safety check, doing an environmental scan, and using proper sling sizes for the residents daily on varied shifts for 7 days, then weekly x 4 weeks and then monthly x 4 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 07/16/2025

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 2 identified that due to R1's multiple fractures and unstable burst fracture of the first cervical vertebra, R1 was transferred to the St. Cloud Hospital for further assessment and care. Clinical impression included closed unstable burst fracture of the first cervical vertebra, closed odontoid (is a specific type of cervical spine injury involving the second cervical vertebra (C2)) fracture with displacement, fracture of the sixth cervical vertebra, and open fracture of nasal bone. R1's quarterly Minimum Data Set (MDS) dated 5/28/25, identified R1 had intact cognition. Diagnoses included at the knee amputations of both legs, paraplegia and rheumatoid arthritis. Identified R1 required staff assist with toileting, dressing, bed mobility, and transferring. R1's care plan last revised on 7/14/25, indicated R1 had a bilateral above the knee amputation in 2019, and required total assist of two (staff) and Hoyer (brand name of a full body mechanical lift) for transfers. The care plan did not identify the sling size staff were to use for transfers. Identified R1 had sutures to her nose and right forehead above the eyebrow with suture removal scheduled for 7/21/25. In addition, R1 had a C1 and C6 (neck) fractures which required a cervical (neck) collar to be worn at all times. In addition, R1 had a nasal fracture and a left femur fracture requiring a leg immobilizer to be worn when R1 was up in wheelchair and during transfers. The facility identified “focus sheet” (abbreviated care plan for nursing assistants (NA)) as of 714/25, indicated R1 required two staff assist with Hoyer Lift however, the sling size was not identified. R1's progress notes dated 7/9/25 at 10:33 a.m., identified R1 was transferred to the ED for a C1, C2, and nasal fracture after a fall from a lift while staff transferred her from bed to wheelchair. R1’s progress note dated 7/11/25 at 4:01 p.m., identified R1 returned from the hospital with the following injuries: laceration with five stitches above her right eye brow; laceration with three stitches in the center of her nose; bruising around right eye and down to the right side of her lips; bruising to her left eye under and on the corner of her inner eye; a	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 07/16/2025

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 3 2.5 centimeter (cm) x 4 cm bruise near her left lateral elbow; two bruises on her left forearm sized 2 cm x 5.5cm and 5cm x 3.5 cm; neck brace on; and leg immobilizer on. R1's last documented weight on 7/14/25, was 136 pounds and previous weight on 7/2/25, was 123.6 pounds. An undated facility document labeled Medcare Products indicated all sling sizing recommendations were provided for patient comfort and fit. For a resident weight of 100-210 lbs. (pounds) a medium sized sling would be indicated. During an observation and interview on 7/14/25 at 11:12 a.m., R1 was sitting in the common area and was noted to have scabs, bruises, sutures to her face with a neck collar on, and an immobilizer brace on her left upper leg. R1 stated she had just returned from the hospital and was having “pain all over, all of the time”. R1 further identified she fell out of the lift fell the top sling loop by the right side of her head came off. When she fell out of the lift, she hit her face and nose on the leg of the lift and her legs hit something when she fell however she was not sure what they hit. R1 stated, “I don’t think they had it [sling] hooked up right” as she stated she used the lift for six years and it had not happened before. R1 indicated she had been in the hospital for a “couple of days” and had “lots of pain all the time”. R1 expressed fear of getting back into the lift sling. During an observation on 7/14/25 at 1:19 p.m., nursing assistant (NA)-G and registered nurse (RN)-A transferred R1 from wheelchair to bed. When asked about the size of the sling, NA-G stated R1 used small slings and observed R1 had a small multipurpose sling under her during transfer and a spare small sling stored in the closet. During an observation on 7/14/25 at 3:02 p.m., NA-F and NA-E prepared to transfer R1 from bed to wheelchair. R1 cried out and moaned in pain while they rolled her to apply a small sling under her. NA-E and NA-F put the loops onto the safety bar and began to lift R1 off the bed. This evaluator stopped the transfer when it was noted that once tension was applied to the sling straps, the sling loop on the upper left side was sitting on top of the safety bar and not down in the	F0689		

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F0689 SS = SQC-J	Continued from page 4 hook area where it was supposed to rest for a safe transfer. NA-E stated, “oh-oh, didn’t I put it [sling loop] all the way down?” NA-F lowered the lift and reapplied the loop to the upper left safety bar in the hook, lifted R1, and attempted to transfer to wheelchair. When R1 was approximately twelve inches above the wheelchair, the lift stopped, and NA-E used a walkie talkie to page the nurse. After a few minutes, licensed practical nurse (LPN)-A responded and explained how to operate the emergency lowering mechanism to both NA's and R1 was safely lowered to the wheelchair. NA-F stated that the battery had died and needed the nurse to assist. During an interview on 7/14/25 at 3:21 p.m., the director of nursing (DON) indicated staff were expected to to use a medium sling for R1, not a small sling. The DON did not know why small slings were stored in R1's room. During an interview with licensed practical nurse (LPN)-A on 7/14/25 at 2:10 p.m., identified she responded on 7/9/25 at 6:50 a.m., when R1 fell from the lift but stated she thought the sling used was a medium and was unhooked and underneath R1 on the floor. LPN-A identified she was not sure what had happened to allow R1 to fall and was just more concerned with getting R1 the emergency care she needed at the time. LPN-A further indicated staff should have used a medium sling for R1 because of her weight but a small sling was R1’s preference so staff had used small slings most of the time. During an interview on 7/15/25 at 2:25 p.m., NA-B identified he assisted NA-A with R1’s transfer on 7/9/25, in the morning. NA-B stated they each hooked two loops of the sling up to the safety bar and raised R1 up out of bed. While they were moving the lift towards the chair, the leg of the lift got caught up in the base of R1’s fan and R1 started leaning to the right and fell out of the right side of the sling. NA-B further identified one of the sling loops had come unhooked during the transfer and thought it was the one on the side R1 fell out of however stated it happened really fast and was not certain. NA-B denied double checking the placement of the loops once tension was applied to the sling straps. During an interview on 7/15/25 at 9:35 a.m., RN-B indicated R1 by weight should have had a medium sling	F0689		

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F0689 SS = SQC-J	Continued from page 5 used however “insists on a small [sling]”. R1 felt the medium sling was too big “did pretty good in it [small sling] but didn’t work when the fall happened”. RN-B indicated staff should be checking the placement of the sling loops as soon as pressure had been applied to the sling straps. RN-B did not know where a resident assessment for proper sling size would be in the medical record and did not think it was documented anywhere. During an interview on 7/15/25 at 9:50 a.m., the maintenance director indicated the full body lift was inspected after R1 fell from it and was found to be in working order. During an interview on 7/15/25 at 11:25 a.m., Medcare customer service representative (CSR) indicated if the full body lift was in working order, the only way for a resident to fall out of a lift would be improper sling set up or not attaching it to the lift safety bar hooks correctly. R2 R2's MDS dated 4/24/25, identified R2 had intact cognition, and diagnosis of paraplegia. R2's care plan dated 4/17/24, indicated R2 transferred with two staff assist and a Hoyer (full body mechanical lift). The care plan did not identify the size sling to use. The facility identified “focus sheet” (abbreviated care plan for nursing assistants (NA)) as of 714/25, indicated R1 required two staff assist with Hoyer Lift but did not identify the sling size to use. R2’s medical record identified R2’s weight on 7/14/25, was 188.4 pounds. An undated facility document labeled Medcare Products indicated all sling sizing recommendations are provided for patient comfort and fit. For a resident weight of 100-210 lbs. (pounds) a medium sized sling was indicated.	F0689		

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F0689 SS = SQC-J	Continued from page 6 During an observation on 7/14/25 at 11:55, NA-C and NA-D transferred R2 out of the tub using a ceiling lift. NA-C indicated R2's sling was a size extra-large but after double checking the size on the sling, it had small written on the sling. NA-C stated, "oh no, it looks much bigger than that," and further identified that she picked that sling out because, "he [R2] likes the softer ones[slings], not the stiffer ones for his bath." NA-C further identified the resident sling size was not written anywhere and staff were directed to size the sling by the resident's weight and their body size. NA-D stated NA's or the nurses could decide what sling to use. During an interview on 7/14/25 at 12:00 p.m., RN-A indicated she did not know who determined what sling size a resident was supposed to use. RN-A stated she did not know how the proper sling or belt size was communicated to the NA's doing the transfers. R2's medical record lacked resident assessment for appropriate sizing of the sling. R3 R3's admission MDS dated 8/22/24, identified R3 had severe cognitive impairment, was dependent on staff for toileting, lower body dressing, transfers, and bed mobility. Diagnoses included dementia, encephalopathy, and osteoarthritis. R3's care plan revised 6/13/25, indicated R3 required assist of one staff with PAL (sit to stand lift) for transfers. The care plan did not identify what size sling belt to use. The facility identified "focus sheet" (abbreviated care plan for nursing assistants (NA)) as of 714/25, indicated R3 transferred with one staff assist and PAL lift (sit to stand lift) but did not identify what size belt should be used. The Medcare Operations Manual Belt Sizing Guide indicates recommended belt size was determined by waist size. R3's medical record did not contain R3's waist size.	F0689		

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F0689 SS = SQC-J	Continued from page 7 R3's medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During observation and interview on 7/14/25 at 12:35 p.m., R3 was sitting in a recliner with an extra-large belt laying in the wheelchair. NA-D entered the room with the sit to stand lift which had a medium belt slung over the top of the lift. NA-D used the medium belt, placed the belt around R3 and hooked it to the lift. NA-D transferred R3 to the bathroom and then back to the chair. During the transfer back to the chair, R3 did remove her left hand from the lift and was holding on to the lift with her right hand only. No observation was noted of NA-D tightening the belt once R3 was lifted or applying the safety shin straps during the transfers. When asked about the two different belt sizes in R3's room, NA-D stated she did not know why there was an extra-large belt in R3's room but that it "keeps showing up in here [R3's room]" but had not used it. R3 indicated belt size was determined by the "resident chest size" and R3 was a "smaller lady and if the extra-large belt were used on her, she would fall right through it". When asked about the safety shin strap, NA-D stated, "I never use them [shin strap]" and thought they were for a previous resident that would not keep his feet on the foot platform. R4 R4's quarterly MDS dated 7/11/25, identified R5 had moderate cognitive impairment and required staff assist for transfers. Diagnoses included lower limb amputation and osteoporosis. R4's care plan last revised 5/7/25, identified R4 required assist of one staff and stand by assist with transfers. The care plan did not identify the use of the mechanical lift or size of belt staff were to use with transfer. The facility identified "focus sheet" as of 7/14/25, indicated R4 transferred with one staff assist and PAL lift (sit to stand lift) but did not identify what size belt should be used. R4's medical record lacked resident assessment for	F0689		

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F0689 SS = SQC-J	Continued from page 8 appropriate sizing of mechanical lift belt. During an observation on 7/15/25 at 1:10 p.m., R4 was noted to have a sit to stand lift in her bathroom with a medium size belt draped over the top. R5 R5's quarterly MDS identified R5 had intact cognition and required staff assistance with transfers. Diagnoses included osteoarthritis and spondylosis (degenerative changes in the spine). R5's care plan last revised 4/23/25, identified R5 required one staff assist for transfers using a PAL lift (sit to stand lift) but did not identify what size belt should be used. The facility identified “focus sheet” as of 7/14/25, indicated R5 transferred with one staff assist and PAL lift (sit to stand lift) but did not identify what size belt staff should use. R5’s medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During an observation on 7/15/25 at 1:17 p.m., R5 was noted to have a size large belt laying on his chair in his room. R6 R6's significant change MDS dated 11/25/24, indicated R6 had severe cognitive impairment and required maximum staff assist with transfers. Diagnosis included dementia. R6's care plan revised initiated on 9/13/24, indicated R6 transferred with two assist and PAL lift but did not identify belt size to use for safe transfers. The facility identified “focus sheet” as of 7/14/25, indicated R6 transferred with two staff assist and PAL	F0689		

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F0689 SS = SQC-J	Continued from page 9 (sit to stand lift) lift for all transfers but did not identify what size belt staff should use. R6's medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During observation on 7/15/25, R6 was noted to have a large sling belt in his room. R8 R8's quarterly MDS dated 5/15/25, identified R8 had moderately impaired cognition and was dependent on staff for all transfers. Diagnoses included cerebral infarction and dementia. R8's care plan reviewed on 7/14/25, indicated R8 transferred with assist of two and Hoyer (full body mechanical lift) but did not identify sling size to use. The facility identified "focus sheet" as of 7/14/25, indicated R8 transferred with two staff assist and Hoyer transfers but did not identify what size sling staff should use. R8's medical record lacked resident assessment for appropriate sizing of mechanical lift sling. R8's vital signs chart indicated R8's weight on 7/8/25, was 215 pounds which indicated a large sling was recommended. During observation and interview on 7/14/25 at 1:47 p.m., NA-D and NA-G transferred R8 to bed using a size large sling. Interview with NA-G indicated she determined sling size by the resident's weight and if she did not know the resident weight she would ask the nurse for the weight. NA-G further indicated R8 used a large because "a medium is way too small". R9	F0689		

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F0689 SS = SQC-J	Continued from page 10 R9's quarterly MDS dated 6/16/25, identified R9 had severe cognitive impairment and was dependent on staff for all transfers. Diagnoses included dementia and fracture of the left acetabulum (hip). R9's care plan on 7/14/25, identified R9 transferred with two staff assist and PAL lift or two staff assist and Hoyer lift but did not identify the size belt or sling to use for transfers. The facility identified “focus sheet” as of 7/14/25, indicated R9 transferred with assist of two and PAL lift or assist of two and a Hoyer lift but did not include the size of the sling or belt to use. R9’s medical record lacked resident assessment for appropriate sizing of mechanical lift belt and sling. R10 R10’s annual MDS dated 2/18/25 indicated R10 had severe cognitive impairment and required assist with all transfers. Diagnosis included Alzheimer’s. R10’s care plan on 7/14/25, identified R10 transferred with two staff assist for pivot transfer; one staff assist with ETAC (unknown meaning) from recliner, wheelchair, bed; or assist of one with PAL lift. The care plan did not identify what belt size to use. The facility identified “focus sheet” as of 7/14/25, indicated R10 transferred with assist of one and ETAC (unknown meaning); assist of two with pivot, or assist of one and PAL. R10’s medical record lacked a waist size or resident assessment for appropriate sizing of mechanical lift belt. During observation and interview on 7/14/25 at 3:44 p.m., NA-G applied a large belt and assisted R10 to transfer. NA-G stated the size belt for the resident depended on the resident weight.	F0689		

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F0689 SS = SQC-J	Continued from page 11 R11 R11's significant change MDS dated 4/23/25, indicated R11 had intact cognition and required staff assist with transfers. Diagnosis included Multiple Sclerosis. R11's care plan on 7/14/25, identified R11 transferred with one staff assist and standing lift but did not identify what size belt to use. The facility identified "focus sheet" as of 7/14/25, indicated R11 required assist of one and PAL but did not identify what size belt to use. R11's medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During an observation on 7/15/25 at 9:02 a.m., NA-H assisted R11 with a transfer to the commode using a medium belt. When asked about determining appropriate belt size for a resident, NA-H stated it depended on "the size person they are" and did not want them too loose so "I just judge their size and how it fits and determine their size from there." NA-H further indicated there was not any direction on which belt size to use but most of the residents that used belts, had them hanging on their doors. R12 R12's quarterly MDS dated 5/5/25, indicated R12 had severe cognitive impairment and was dependent on staff for transfers. Diagnosis included Alzheimer's. R12's care plan on 7/14/25, identified R12 transferred with one staff assist and standing lift but did not identify what size belt to use. The facility identified "focus sheet" as of 7/14/25, indicated R12 assist of one and PAL but did not identify what size belt to use. R12's medical record lacked resident assessment for appropriate sizing of mechanical lift belt.	F0689		

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F0689 SS = SQC-J	Continued from page 12 During an interview on 7/15/25 at 9:13 a.m., NA-I indicated most of the residents that used lifts had slings or belts on the back of their doors that they could use but slings and belts for the mechanical lifts were based on the resident weight. NA-I denied any written communication to instruct what size sling or belt they were to use. During an interview on 7/15/25 at 9:20 a.m., LPN-A identified NAs should refer to the belt sizing guide in the CNA book binder at the nurse's desk when determining belt size. LPN-A further indicated all sling were determined by a resident's weight but did not know and could not find any sizing recommendation information on the sit to stand belts and stated, "I guess they go by weight too." During an interview with on 7/15/25 at 12:20 p.m., RN C indicated she did not know who did resident assessments for sling sizing and was not aware of a specific assessment process the facility had in place. During a follow-up interview on 7/15/25 at 12:25 p.m., the DON identified the RN charge nurse should identify the residents sling or belt size based on the size guide sheet from the manufacturer and would be based on the resident body type and weight. The DON confirmed the facility did not have a formal assessment to determine sling or belt size and did not know where staff would document the resident sling and belt sizes. The DON indicated residents should have the appropriate size sling or belt on the back of their doors to ensure safety. The DON identified after R1's fall from the lift, she replaced the small slings in R1's room with the medium sling and did not know how the small slings ended up in use for R1 again after she had removed them. The DON confirmed the facility did not train or complete competencies for lift use on the temporary agency staff however planned to initiate that immediately. The DON verified the facility policy addressed the use of a lift that was not in service at their facility and did not have one specific to the Medcare brand lifts that were currently being used. The facility policy titled, Reliant 450 Lift and Slings (the facility is using Medcare full body lift and slings) dated 5/28/2008, and last modified on 7/14/25, indicated before beginning procedure, scan the	F0689		

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F0689 SS = SQC-J	Continued from page 13 environment for obstacles to making a successful transfer and adjust environment to ensure safety of resident. Step 1 is to select the proper style and size sling (binding around each sling is color coded to size, the sizing chart is in each CNA book). Step 21 is prior to lifting an individual make sure the straps of the slings are securely placed on the hooks of the carry bar. The facility policy titled, Med Care Standing Lift dated 5/28/2008 and last updated 7/14/25, identified the stand lift is intended for residents who are able to bear partial weight and require some lifting to perform activities of daily living. Appropriate use is to be determined by physical therapy department or nurse managers. Step 5 instructs to hook the leg strap around the resident's calves. Step 7 is prior to lifting an individual make sure the straps of the slings are securely placed on the hooks of the carry bar. Upon admission or change of condition, sit to stand lifts will be two assist, unless deemed to be safe with one assist by a licensed nurse or therapy. The policy does not include any language regarding how to accurately size the harnass (belt) for the resident. The Medcare Sling Sizing Guide directs staff to use the sling sizing chart as a general guide. Keep in mind the patients/residents that are the same weight may have different body types, shapes, and sizes and may require different sized slings. The Medcare Belt Sizing Guide directs staff to use the belt sizing chart as a general guide. Keep in mind the patients/residents that are the same weight may have different body types, shapes, and sizes and may require different sized belts. The sizing guide gives recommended size by waist size. Waist size of 24 inches to 48 inches recommends a small size; 30 inches to 54 inches recommends a medium size; 36 inches to 60 inches recommends a large size; and 42 inches to 66 inches recommends an extra-large size. The sizing guide does not identify that weight is used in sizing the belts. The IJ was removed on 7/16/25 at 2:11 p.m. when it was verified the facility implemented the following corrective actions: *The facility policy and procedure for safe mechanical lift transfers was updated to include the appropriate mechanical lift company's manufacturer's	F0689		

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F0689 SS = SQC-J	Continued from page 14 recommendations and specific time out procedures to do safety checks to ensure all loops were hooked on the appropriate hook before lifting the resident and completing an environmental scan of all the area for possible obstacles prior to beginning the lifting procedure. *The facility developed and implemented a system for an RN to comprehensively assess sling and belt sizes for individual residents utilizing the full body and sit to stand mechanical lifts by utilizing the manufacturer's guidelines and nursing judgement. * Sling and belt sizes for each resident were added to the resident's care plans and the NA care sheets (focus sheets). *The facility provided education with return demonstration to all nursing staff on manufacturer's recommendations to include a safety check, doing an environmental scan, and using proper sling sizes for the residents.	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 **07/16/2025**

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 7/14/25 to 7/16/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the 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		08/13/2025

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: H55739207C (MN00114530 and MN00114508) with a licensing order issued at 0830. 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 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		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to	20830	Corrected	08/13/2025

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20830	Continued from page 2 remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and document review the facility failed to safely use a mechanical lift per manufactures recommendations to transfer 1 of 11 residents (R1), who required a mechanical lift for transfers. This resulted in an immediate jeopardy (IJ) when R1 fell from a full body mechanical lift causing R1 to suffer fractures to her cervical spine (C1 and C6), nasal cavity, and left femur as well as lacerations to facial area requiring hospital admission. In addition, the facility failed to ensure a system for completed comprehensive assessments for sling size and/or care plan development for 9 of 11 residents (R1, R2, R3, R5, R6, R8, R9, R10, R11) reviewed who required mechanical lifts. The IJ began on 7/9/25, when staff failed to ensure lift sling was properly secured prior to the transfer causing R1 to fall from the mechanical lift. The administrator and director of nursing (DON) were notified of the IJ on 7/15/25 at 4:20 p.m. The IJ was removed on 7/16/25 at 2:11 p.m., when the facility had implemented immediate corrective action to prevent recurrence, but noncompliance remained at a lower scope and severity of a D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings included: A Facility Reported Incident (FRI) submitted to the state Agency (SA) on 7/9/25 at 9:25 a.m., alleged potential caregiver neglect when R1 fell from the mechanical lift during a transfer and sustained a large gash above right eyebrow and on her nose. R1 was transferred by ambulance to the emergency department. During an observation and interview on 7/14/25 at 11:12 a.m., R1 was sitting in the common area and was noted to have scabs, bruises, sutures to her face with a neck collar on, and an immobilizer brace on her left upper leg. R1 stated she had just returned from the hospital and was having “pain all over, all of the time”. R1 further identified she fell out of the lift when the top sling loop by the right side of her head came off and she fell out of the lift. When she fell out of the lift, she hit her face and nose on the leg of the lift and her legs hit something when she fell but she was not sure what they hit. R1 stated, “I don’t think they had it [sling] hooked up right” as she stated she used	20830		

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20830	Continued from page 3 the lift for six years and it had not happened before. R1 indicated she had been in the hospital for a “couple of days” and had “lots of pain all the time”. R1 expressed fear of getting back into the lift sling. R1's quarterly Minimum Data Set (MDS) dated 5/28/25 identified R1 had intact cognition. Diagnoses included at the knee amputations of both legs, paraplegia, diabetes, and rheumatoid arthritis. The MDS also identified R1 required staff assist with toileting, dressing, bed mobility, and transferring. R1's care plan last revised on 7/14/25, indicated R1 had a bilateral above the knee amputation in 2019 and required total assist of two (staff) and Hoyer (brand name of a full body mechanical lift) for transfers. The care plan did not identify the sling size staff were to use for transfers. The care plan also identified R1 had sutures to her nose and right forehead above the eyebrow with suture removal scheduled for 7/21/25. In addition, R1 had a C1 and C6 (neck) fractures which required a cervical (neck) collar to be worn at all times. R1 also had a nasal fracture and a left femur fracture requiring a leg immobilizer to be worn when R1 was up in wheelchair and during transfers. The facility identified “focus sheet” (abbreviated care plan for nursing assistants (NA)) as of 714/25, indicated R1 required two staff assist with Hoyer Lift but sling size was not identified. R1's last documented weight on 7/14/25 was 136 pounds and previous weight on 7/2/25 was 123.6 pounds. An undated facility document labeled Medcare Products indicates all sling sizing recommendations are provided for patient comfort and fit. For a resident weight of 100-210 lbs. (pounds) a medium sized sling would be indicated. R1's progress notes dated 7/9/25 at 10:33 a.m., identified R1 was transferred for a C1, C2, and nasal fracture after a fall from a lift while staff transferred her from bed to wheelchair. R1’s progress note dated 7/11/25 at 4:01 p.m., identified R1 returned from the hospital had the following injuries: laceration with five stitches above her right eye brow; laceration with three stitches in the center of her nose; bruising around right eye and down to the right side of her lips; bruising to her left eye under and on the corner of her inner eye; a 2.5 centimeter (cm) x 4 cm bruise near her left lateral elbow; two bruises on her left forearm sized 2 cm x	20830		

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20830	Continued from page 4 5.5cm and 5cm x 3.5 cm; neck brace on; and leg immobilizer on. During an observation on 7/14/25 at 1:19 p.m., nursing assistant (NA)-G and registered nurse (RN)-A transferred R1 from wheelchair to bed. When asked about the size of the sling, NA-G stated R1 used small slings and observed R1 had a small multipurpose sling under her during transfer and a spare small sling in the closet. During an observation on 7/14/25 at 3:02 p.m. NA-F and NA-E prepared to transfer R1 from bed to wheelchair. R1 cried out and moaned in pain while they rolled her to apply a small sling under her. NA-E and NA-F put the loops onto the safety bar and began to lift R1 off the bed. This evaluator stopped the transfer when it was noted that once tension was applied to the sling straps, the sling loop on the upper left side was sitting on top of the safety bar and not down in the hook area where it was supposed to rest for a safe transfer. NA-E stated, “oh-oh, didn’t I put it [sling loop] all the way down?” NA-F lowered the lift and reapplied the loop to the upper left safety bar in the hook, lifted R1, and attempted to transfer to wheelchair. When R1 was approximately twelve inches above the wheelchair the lift stopped, and NA-E used a walkie talkie to page the nurse. After a few minutes, licensed practical nurse (LPN)-A responded and explained the emergency lowering mechanism and R1 was safely lowered to the wheelchair. NA-F stated that the battery had died and needed the nurse to assist. During an interview on 7/14/25 at 3:21 p.m., the director of nursing (DON) indicated R1 was supposed to use a medium sling, not a small sling. The DON did not know why R1 had small slings in her room. During an interview with licensed practical nurse (LPN)-A identified she responded on 7/9/25 at 6:50 a.m., when R1 fell from the lift but stated she thought the sling was a medium and was unhooked and underneath R1 on the floor. LPN-A identified she was not sure what had happened to allow R1 to fall but was just more concerned with getting R1 the emergency care she needed. LPN-A further indicated R1 should have used a medium sling because of her weight but a small sling was R1’s preference so had used small slings most of the time. During an interview on 7/15/25 at 2:25 p.m., NA-B identified he assisted NA-A with R1’s transfer on 7/9/25 in the morning. NA-B stated they each hooked two loops of the sling up to the safety bar and raised R1	20830		

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20830	Continued from page 5 up out of bed. While they were moving the lift towards the chair the leg of the lift got caught up in the base of R1's fan and R1 started leaning to the right and fell out of the right side of the sling. NA-B further identified one of the sling loops had come unhooked during the transfer and thought it was the one on the side R1 fell out of but stated it happened really fast. NA-B was not sure. NA-B denied double checking the placement of the loops once tension was applied to the sling straps. During an interview on 7/15/25 at 9:35 a.m., RN-B indicated R1 by weight should be a medium sling but "insists on a small [sling]". R1 felt the medium sling was too big "did pretty good in it [small sling] but didn't work when the fall happened". RN-B indicated staff should be checking the placement of the sling loops as soon as pressure had been applied to the sling straps. RN-B did not know where a resident assessment for proper sling size would be in the medical record fand did not think it was documented anywhere. During an interview on 7/15/25 at 9:50 a.m., the maintenance director indicated the full body lift was inspected after R1 fell from it and was found to be in working order. During an interview on 7/15/25 at 11:25 a.m., Medcare customer service representative (CSR) indicated if the full body lift was in working order, the only way for a resident to fall out of a lift would be improper sling set up or not attaching it to the lift safety bar hooks correctly. R2 R2's admission Minimum Data Set (MDS) dated 4/24/25, identified R2 had intact cognition, and diagnoses included paraplegia and diabetes. R2's care plan dated 4/17/24, indicated R2 transferred with two staff assist and a Hoyer (full body mechanical lift). The care plan did not identify the size sling to use. The facility identified "focus sheet" (abbreviated care plan for nursing assistants (NA)) as of 714/25, indicated R1 required two staff assist with Hoyer Lift but did not identify the sling size to use. R2's medical record identified R2's weight on 7/14/25 was 188.4 pounds.	20830		

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20830	Continued from page 6 An undated facility document labeled Medcare Products indicates all sling sizing recommendations are provided for patient comfort and fit. For a resident weight of 100-210 lbs. (pounds) a medium sized sling would be indicated. During an observation on 7/14/25 at 11:55, NA-C and NA-D transferred R2 out of the tub using a ceiling lift. NA-C indicated R2's sling was a size extra-large but after double checking the size on the sling, it had small written on the sling. NA-C stated, "oh no, it looks much bigger than that," and further identified that she picked that sling out because, "he [R2] likes the softer ones[slings], not the stiffer ones for his bath." NA-C further identified the resident sling size was not written anywhere and were directed to size the sling by the resident's weight and their body size. NA-D also identified that the NA's or the nurses could decide what sling to use. During an interview on 7/14/25 at 12:00 p.m., RN-A indicated she did not know who determined what sling size a resident was supposed to use. RN-A also stated she did not know how the proper sling or belt size was communicated to the NA's doing the transfers. R3 R3's admission MDS dated 8/22/24, identified R3 has severe cognitive impairment, was dependent on staff for toileting, lower body dressing, transfers, and bed mobility. Diagnoses included dementia, encephalopathy, and osteoarthritis. R3's care plan revised 6/13/25, indicated R3 required assist of one staff with PAL (sit to stand lift) for transfers. The care plan did not identify what size belt to use. The facility identified "focus sheet" (abbreviated care plan for nursing assistants (NA)) as of 714/25, indicated R3 transferred with one staff assist and PAL lift (sit to stand lift) but did not identify what size belt should be used. The Medcare Operations Manual Belt Sizing Guide indicates recommended belt size was determined by waist	20830		

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20830	Continued from page 7 size. R3's medical record did not contain R3's waist size. During observation and interview on 7/14/25 at 12:35 p.m., R3 was sitting in a recliner with an extra-large belt laying in the wheelchair. NA-D entered the room with the sit to stand lift which had a medium belt slung over the top of the lift. NA-D used the medium sling, placed the sling around R3 and hooked it to the lift. NA-D then transferred R3 to the bathroom and then back to the chair. During the transfer back to the chair, R3 did remove her left hand from the lift and was holding on to the lift with her right hand only. No observation of NA-D tightening the belt once R3 was lifted or applying the safety shin straps during the transfers. When asked about the two different sling sizes in R3's room, NA-D stated she did not know why there was an extra-large belt in R3's room but that it "keeps showing up in here [R3's room]" but had not used it. R3 indicated belt size was determined by the "resident chest size" and R3 was a "smaller lady and if the extra-large belt were used on her, she would fall right through it". When asked about the safety shin strap, NA-D stated, "I never use them [shin strap]" and thought they were for a previous resident that would not keep his feet on the foot platform. R4 R4's quarterly Minimum Data Set (MDS) dated 7/11/25, identified R5 had moderate cognitive impairment, required staff assist for transfers. Diagnoses included lower limb amputation, kidney disease, and osteoporosis. R4's care plan last revised 5/7/25, identified R4 required assist of one staff and stand by assist with transfers. The care plan did not identify the use of the mechanical lift or size of belt staff were to use with transfer. The facility identified "focus sheet" as of 7/14/25, indicated R4 transferred with one staff assist and PAL lift (sit to stand lift) but did not identify what size belt should be used. R4's medical record lacked resident assessment for appropriate sizing of mechanical lift belt.	20830		

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20830	Continued from page 8 During an observation on 7/15/25 at 1:10 p.m., R4 was noted to have a sit to stand lift in her bathroom with a medium size sling draped over the top. R5 R5's quarterly Minimum Data Set (MDS) identified R5 had intact cognition and required staff assistance with transfers. Diagnoses included osteoarthritis and spondylosis (degenerative changes in the spine). R5's care plan last revised 4/23/25, identified R5 required one staff assist for transfers using a PAL lift (sit to stand lift) but did not identify what size belt should be used. The facility identified “focus sheet” as of 7/14/25, indicated R5 transferred with one staff assist and PAL lift (sit to stand lift) but did not identify what size belt staff should use. R5’s medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During an observation on 7/15/25 at 1:17 p.m., R5 was noted to have a size large belt laying on his chair in his room. R6 R6's significant change MDS dated 11/25/24, indicated R6 had severe cognitive impairment and required maximum staff assist with transfers. Diagnoses included dementia, kidney disease, and heart failure. R6's care plan revised initiated on 9/13/24, indicated R6 transferred with two assist and PAL lift but did not identify belt size to use for safe transfers. The facility identified “focus sheet” as of 7/14/25, indicated R6 transferred with two staff assist and PAL (sit to stand lift) lift for all transfers but did not identify what size belt staff should use.	20830		

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20830	Continued from page 9 R6's medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During observation on 7/15/25, R6 was noted to have a large sling belt in his room. R8 R8's quarterly Minimum Data Set (MDS) dated 5/15/25, identified R8 had moderately impaired cognition and was dependent on staff for all transfers. Diagnoses included cerebral infarction, dementia, and diabetes. R8's care plan reviewed on 7/14/25, indicated R8 transferred with assist of two and Hoyer (full body mechanical lift) but did not identify sling size to use. The facility identified "focus sheet" as of 7/14/25, indicated R8 transferred with two staff assist and Hoyer transfers but did not identify what size belt staff should use. R8's medical record lacked resident assessment for appropriate sizing of mechanical lift belt. R8's vital signs chart indicated R8's weight on 7/8/25 was 215 pounds which indicated a large sling was recommended. During observation and interview on 7/14/25 at 1:47 p.m., NA-D and NA-G transferred R8 to bed using a size large sling. Interview with NA-G indicated she determined sling size by the resident's weight and if she did not know the resident weight she would ask the nurse for the weight. NA-G further indicated R8 uses a large because "a medium is way too small. R9 R9's quarterly MDS dated 6/16/25, identified R9 had severe cognitive impairment and was dependent on staff for all transfers. Diagnoses included dementia, fracture of the left acetabulum (hip), and diabetes.	20830		

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20830	Continued from page 10 R9's care plan on 7/14/25, identified R9 transferred with two staff assist and PAL lift or two staff assist and Hoyer lift but did not identify the size sling to use for transfers. The facility identified “focus sheet” as of 7/14/25, indicated R9 transferred with assist of two and PAL lift or assist of two and a Hoyer lift but did not include the size of the sling or belt to use. R9’s medical record lacked resident assessment for appropriate sizing of mechanical lift belt. R10 R10’s annual MDS dated 2/18/25 indicated R10 had severe cognitive impairment and required assist with all transfers. Diagnoses included Alzheimer’s, diabetes, and kidney disease. R10’s care plan on 7/14/25, identified R10 transferred with two staff assist for pivot transfer; one staff assist with ETAC (unknown meaning) from recliner, wheelchair, bed; or assist of one with PAL lift. The care plan did not identify what belt size to use. The facility identified “focus sheet” as of 7/14/25, indicated R10 transferred with assist of one and ETAC (unknown meaning); assist of two with pivot, or assist of one and PAL. R10’s medical record lacked a waist size or resident assessment for appropriate sizing of mechanical lift belt. During observation and interview on 7/14/25 at 3:44 p.m., NA-G applied a large belt and assisted R10 to transfer. NA-G stated the size belt for the resident depended on the resident weight. R11 R11’s significant change MDS dated 4/23/25 indicated R11 had intact cognition and required staff assist with transfers.	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/16/2025**

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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20830	Continued from page 11 R11's care plan on 7/14/25, identified R11 transferred with one staff assist and standing lift but did not identify what size belt to use. The facility identified "focus sheet" as of 7/14/25, indicated R11 assist of one and PAL but did not identify what size belt to use. R11's medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During an observation on 7/15/25 at 9:02 a.m., NA-H assisted R11 with a transfer to the commode using a medium sling. When asked about determining appropriate sling size for a resident, NA-H stated it depended on "the size person they are" and did not want them too loose so "I just judge their size and how it fits and determine their size from there." NA-H further indicated there was not any direction on which sling size to use but most of the residents that used slings, had them hanging on their doors. R12 R12's quarterly MDS dated 5/5/25 indicated R12 had severe cognitive impairment and was dependent on staff for transfers. Diagnoses included Alzheimer's, diabetes, and kidney disease. R12's care plan on 7/14/25, identified R12 transferred with one staff assist and standing lift but did not identify what size belt to use. The facility identified "focus sheet" as of 7/14/25, indicated R12 assist of one and PAL but did not identify what size belt to use. R12's medical record lacked resident assessment for appropriate sizing of mechanical lift belt. During an interview on 7/15/25 at 9:13 a.m., NA-I indicated most of the residents that use lifts have slings on the back of their doors that they could use but slings and belts for the mechanical lifts were based on the resident weight. NA-I denied any written	20830		

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20830	Continued from page 12 communication to instruct what size sling or belt they were to use. During an interview on 7/15/25 at 9:20 a.m., LPN-A identified NAs should refer to the sling sizing guide in the CNA book binder at the nurse's desk when determining sling size. LPN-A further indicated all sling were determined by a resident's weight but did not know and could not find any sizing recommendation information on the sit to stand belts and stated, "I guess they go by weight too." During an interview with on 7/15/25 at 12:20 p.m., RN C indicated she did not know who did resident evaluations for sling sizing. During an interview on 7/15/25 at 12:25 p.m., the DON identified the RN charge nurse should identify the residents sling or belt size based on the size guide sheet from the manufacturer and would be based on the resident body type and weight. The DON was not aware of where the resident sling sizes would be documented at and did not have a formal assessment. The DON further identified residents should have the appropriate size sling on the back of their doors. The DON also identified after R1's fall from the lift, she replaced the small slings in R1's room with the medium sling and did not know how the small slings ended up in use for R1 again after she took them out. The DON also indicated the facility does not train or complete competencies on the temporary agency staff but plan to initiate that immediately. The DON also verified the facility policy addressed the use of a lift that was not in service at their facility and did not have one specific to the Medcare brand lifts that were being used. The facility policy titled, Reliant 450 Lift and Slings (the facility is using Medcare full body lift and slings) dated 5/28/2008 but last modified on 7/14/25, indicated before beginning procedure, scan the environment for obstacles to making a successful transfer and adjust environment to ensure safety of resident. Step 1 is to select the proper style and size sling (binding around each sling is color coded to size, the sizing chart is in each CNA book). Step 21 is prior to lifting an individual make sure the straps of the slings are securely placed on the hooks of the carry bar.	20830		

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20830	Continued from page 13 The facility policy titled, Med Care Standing Lift dated 5/28/2008 and last updated 7/14/25, identified the stand lift is intended for residents who are able to bear partial weight and require some lifting to perform activities of daily living. Appropriate use is to be determined by physical therapy department or nurse managers. Step 5 instructs to hook the leg strap around the resident's calves. Step 7 is prior to lifting an individual make sure the straps of the slings are securely placed on the hooks of the carry bar. Upon admission or change of condition, sit to stand lifts will be two assist, unless deemed to be safe with one assist by a licensed nurse or therapy. The policy does not include any language regarding how to accurately size the harnass (belt) for the resident. The Medcare Sling Sizing Guide directs to use the sling sizing chart as a general guide. Keep in mind the patients/residents that are the same weight may have different body types, shapes, and sizes and may require different sized slings. The Medcare Belt Sizing Guide directs to use the sling sizing chart as a general guide. Keep in mind the patients/residents that are the same weight may have different body types, shapes, and sizes and may require different sized belts. The sizing guide gives recommended size by waist size. Waist size of 24 inches to 48 inches recommends a small size; 30 inches to 54 inches recommends a medium size; 36 inches to 60 inches recommends a large size; and 42 inches to 66 inches recommends an extra-large size. The sizing guide does not identify that weight is used in sizing the belts. The IJ was removed on 7/16/25 at 2:11 p.m. when it was verified the facility implemented the following corrective actions: *The facility updated the policy and procedure for safe mechanical lift transfers was updated to include the appropriate mechanical lift company's manufacturers recommendations and specific time out procedures to do safety checks to ensure all loops are hooked on the appropriate hook before lifting the resident and completing an environmental scall of all the area for possible obstacles prior to beginning the lifting procedure. *The facility developed and implemented a system for an RN to comprehensively assess sling and belt sizes for	20830		

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20830	Continued from page 14 individual residents utilizing the full body and sit to stand mechanical lifts by utilizing the manufacturer's guidelines and nursing judgement. * Sling and belt sizes for each resident were added to the resident's care plans and the NA care sheets (focus sheets). *The facility provided education with return demonstration to all nursing staff on manufacturer's recommendations to include a safety check, doing an environmental scan, and using proper sling sizes for the residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		