STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245573	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clara City Care Center	1012 North Division Street Clara City, MN 56222

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on observation, interview, and record review the facility failed to ensure 1 of 3 residents (R1) were treated with dignity and respect. Findings include: Review of facility reported incident dated 5/14/24, indicated trained medication aide (TMA-C) was administering R1's morning medications one 5/11/24, when nursing assistant (NA-L) asked if R1 was ready for breakfast. TMA-C stated R1 was finishing her Miralax (a laxative) when NA-L lunged toward R1 from behind R1 and grabbed the cup out of R1's hand when R1 refused to give up the cup. R1 screamed very loudly Damn it stop and leave me alone and continued to hold the cup fiercely. NA-L was hanging on to the cup tightly and TMA-C was trying to get the cup away from both R1 and NA-L. NA-L stated R1 did not need the Miralax right before she attempted to take the cup away from R1. R1 was visibly shaking and upset. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment, with diagnoses that included altered mental status, aphasia (inability to communicate), stroke, and constipation. R1 was dependent on staff for wheelchair mobility, required maximal assist of one staff for bed mobility, hygiene, transfers, and dressing. R1 did not have a toileting program and was frequently incontinent of bowel and bladder. R1 had verbal behaviors one to three days towards others. R1's care plan indicated the following: -Behavior Symptoms Care plan dated 10/24/23, with interventions of: -avoid over stimulation, -avoid power struggles, -maintain a calm environment and approach. -Communication care plan dated 11/08/22, with interventions of: -talk with R1 in a quiet environment so it is easier for R1 to hear (dated 11/8/22). (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's physician orders included the following: -Miralax (laxative) 17 grams by mouth every other day for constipation (start date 10/10/23) During an interview on 5/15/24 at 2:00 p.m., TMA-C stated she was administering R1's medications crushed in applesauce and the Miralax mixed in 140 mls of water, when NA-L came and asked if R1 was ready to breakfast. TMA-C stated NA-L quickly moved towards R1 from behind and grabbed the glass of Miralax stating R1 did not need the laxative as she had a blow out the day before. There was struggle between R1 and NA-L. TMA-C intervened and was able to stop the struggle and removed the cup from both R1 and NA-L. TMA-C calmed R1 by reassuring her and removed the glass from R1's hands. R1 was visibly shaking and upset. TMA-C stated NA-L was not treating R1 respectfully. TMA-C sent a text message of the incident to the director of nursing (DON), who was on vacation, and the resource- registered nurse (RN-K). During an interview on 5/15/24 at 1:24 p.m., RN-I stated she was the charge nurse during the time frame of the incident between R1 and NA-L, however, was not aware of the incident until it was brought to her attention by the surveyor. RN-I did not think R1 was treated with respect and dignity by NA-L and should have been. During an interview on 5/15/24 at 1:44 p.m., RN-K stated she was made aware of the incident by text message from TMA-C. RN-K did not think NA-L treated R1 respectfully and should have been. During an interview on 5/15/24 at 2:22 p.m., social worker (SW)-A stated she was not made aware of the incident until 5/13/24, when TMA-C informed her around 2:00 p.m. SW-A did not think NA-L treated R1 with respect and dignity. During an interview on 5/15/24 at 2:48 p.m., DON stated she was on vacation and was made aware of incident on Monday, 5/13/24, by the administrator's phone call. DON stated NA-L did not treat R1 with respect and dignity. DON expected all staff to treat all residents with respect and dignity. Review of the facility's undated policy titled Resident Respect and Dignity, indicated that residents had the right to be treated with respect and dignity.