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	10/23/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interviews, the facility failed to develop and implement comprehensive care plans for 2 of 3 residents (R1, R2) reviewed for elopement. Findings include: R1 was admitted to the facility on [DATE]. R1's face sheet dated 10/22/25, indicated diagnoses of dementia, depression, and anxiety.R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had mild cognitive impairment and required staff assistance for activities of daily living with transfers and ambulation. R1 used a wheelchair for locomotion. R1's elopement risk assessment dated [DATE], identified at risk for elopement related to resident being independent in wheelchair locomotion, cognitive impairment and making statements that he was leaving. R1 was at risk for elopement. R1's care plan dated 9/26/25, identified an elopement problem. The care plan indicated R1 was a t risk for elopement related to making statement of leaving to go home. The goal was for R1 to not elope from the facility during the next 90 days. The only intervention was a Wander Guard on R1's ankle; the care plan did not identify individualized interventions to manage R1's elopement risk and/or statements of leaving the facility. R1's progress note dated 10/2/25, at 3:41 p.m., indicated R1 had exit seeking behaviors when he put on his coat, went towards an exit and stated he was going home. There was no indication R1's care plan was reviewed/revised after R1 demonstrated exit seeking behaviors. R1's progress note dated 10/13/25 at 3:45 a.m., identified registered nurse (RN)-A received a call from a passerby that they had a resident. No injuries identified during the skin assessment. R1 was put back to bed, safety checks were implemented. RN-A assessed all doors in the facility besides the emergency only doors in the unused part of the building. R2R2 was admitted to the facility on [DATE]. R2's face sheet dated 10/21/25, indicated diagnoses of hemiplegia (partial paralysis) following cerebral infarction (stroke), cognitive deficit following other cerebrovascular disease, insomnia, anxiety and unspecified symptoms involving cognitive functions and awareness. R2's annual MDS assessment dated [DATE] indicated R2 was cognitively intact and required moderate assistance for activities of daily living.R2's elopement evaluation dated 6/9/25 indicated R2 was independent in locomotion, had cognitive impairment and had displayed behavior that may indicate an attempt to leave and that an elopement may be forthcoming. R2 was at risk for elopement. R2's care plan dated 10/21/25, listed a problem with safety and falls. An approach listed for the fall risk was Wander Guard to wheelchair handle. The care plan did not have a focus area related to elopement and did not have any individualized interventions for exit seeking behavior. On 10/21/25 at 3:07 p.m., registered nurse (RN)-A was interviewed and stated on 10/13/25 at approximately 11:00 pm., R1 came over and asked for the sign out book, had all of his belongings with him and said he was leaving. RN-A stated she did not do anything such as increasing supervision or trying elopement interventions because she was busy with another resident. RN-A verified staff had radios to communicate with each other. RN-A did not communicate with the nursing assistants to increase supervision or try elopement interventions. On 10/22/25 at 12:20 p.m , the director of nursing (DON) was interviewed and stated R1's care plan had not been updated yet to include individualized interventions for his exit seeking behavior and it was not part of the remaining follow up after the elopement event. On 10/22/25 at 12:30 p.m., trained medical assistant (TMA)-A, was interviewed and stated that the care plan should indicate if a resident is at risk for elopement. On 10/22/25 at 12:45 p.m., RN-B was interviewed and stated residents who are elopement risks have a section about safety and falls in their care plans. There are interventions staff are doing that is not documented in the care plans when residents had been exit seeking. RN-B said those interventions could be added to the care plans. On 10/22/25 at 1:30 p.m., nursing assistant (NA)-B was interviewed, and was able to list interventions for each resident with exit seeking behaviors but was unsure where those interventions were documented. The facility policy, Resident MDS and Care Planning, last modified on 1/13/21 directs that all residents will have a comprehensive assessment completed upon admission, annually and with a significant change. Risk factors and assessment to be competed by a nurse on an admission, quarterly and PRN and includes elopement.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure doors were secured and failed to implement individualized interventions to prevent/reduce the risk of elopement for 1 of 3 residents (R1) who had a history of exit seeking behaviors. This resulted in an immediate jeopardy (IJ) when R1 eloped from the facility through two unsecured doors and the wander guard alarm did not work. R1 was later found and returned to the facility by a passerby. The IJ began on 10/13/25, when staff failed to identify doors were not secured and failed to develop and implement appropriate interventions when R1 displayed exit seeking behaviors and left the building unwitnessed. The director of nursing (DON) was notified of the IJ on 10/22/25 at 3:05 p.m. The IJ was removed on 10/23/25 at 4:15 p.m., when the facility implemented immediate corrective action to prevent recurrence, but noncompliance remained at a lower scope and severity of D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R1 was admitted to the facility on [DATE]. R1's face sheet dated 10/22/25, indicated diagnoses of dementia, depression, and anxiety. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had mild cognitive impairment and required staff assistance for activities of daily living with transfers and ambulation. R1 used a wheelchair for locomotion. R1 did not have behaviors or range of motion limitations. R1's elopement risk assessment dated [DATE], identified at risk for elopement related to resident being independent in wheelchair locomotion, cognitive impairment and making statements that he was leaving. R1's care plan dated 9/26/25, identified an elopement problem. The care plan indicated R1 was a t risk for elopement related to making statements of leaving to go home. The goal was for R1 to not elope from the facility during the next 90 days. The only intervention was a Wander Guard on R1's ankle. The care plan also identified R1 as a fall risk. R1's progress note dated 10/2/25, at 3:41 p.m., indicated R1 had exit seeking behaviors when he put on his coat, went towards an exit and stated he was going home. There was no indication R1's care plan was reviewed/revised after R1 demonstrated exit seeking behaviors (Documentation for subsequent care planning or new interventions following this incident was requested but not received.) R1's progress note dated 10/7/25, indicated R1 had an unwitnessed fall with no injuries. R1's progress note dated 10/13/25 at 3:45 a.m., identified registered nurse (RN)-A received a call from a passerby that they had a resident (R1). No injuries identified during the skin assessment. R1 was put back to bed, safety checks were implemented. RN-A assessed all doors in the facility besides the emergency only doors in the unused part of the building. On 10/13/25 at 11 p.m., the temperature in [NAME] City was 49 degrees Fahrenheit per Localconditions.com The nursing home is located on the corner of Division Street (one of the main roads in town) and 40th street where curbs buffer the street right outside the facility. The east side of the building is next to corn fields. There is an operating railroad approximately one mile south of the facility. The State Agency 5-day report dated 10/16/25, included nursing assistant (NA)-A's interview. The report indicated on the evening of 10/13/25 at around 11:00 p.m. R1 asked NA-A to help tie his bag with his belongings. NA-A asked if he was leaving and R1 said yes. NA-A said ok and went to the nursing station. Approximately 5 minutes later, R1 came to the nurse's station and asked how to sign out. NA-A told R1 to go talk to the nurse about it. On 10/21/25 at 12:04 p.m., a call was placed to nursing assistant (NA)-A however it was not answered, there was no return call. During an interview on 10/21/25 at 3:07 p.m., RN-A indicated the evening of 10/13/25, R1 asked her about the sign out book and stated he was leaving. RN-A told R1 it is the middle of the night, and no one is coming to pick you up. R1 turned around and wheeled himself to the other end of the building. RN-A did not communicate to NA's R1 was exit seeking nor increased supervision and/or changed the care plan. RN-A was not aware R1 had exited the building until the passerby called the facility; she did not get any specific information from the passerby such as exact location where R1 was found and R1's mental status. RN-A indicated she had seen R1 approximately 30 minutes prior to the call when he had asked to leave; R1 had been wearing a sweatshirt, sweatpants, and tennis shoes. RN-A was not aware that the exit doors that were supposed to be locked were unlocked at the time R1 left the facility because she had not checked them. RN-A stated she implemented every 2-hour checks, however, was unable to articulate how she determined every two hours was appropriate or individualized. During an interview on 10/21/25 at 2:08 p.m., social worker (SW) stated R1 was able to show her which hallway he went down and which doors he exited the facility from. He recognized duct work in between the two exit doors. Outside, R1 told the social worker he recognized the curb that he went down in his wheelchair. During an interview on 10/22/25 at 8:22 a.m.