

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Clara City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 North Division Street Clara City, 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 0689 Level of Harm - Actual harm 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)

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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(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 - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to adequately supervise a resident to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents and supervision. R1 had a chair alarm that would sound when R1 would stand. The chair alarm prompted staff to respond to R1 after standing. R1 was found on her bathroom floor, transferred to the hospital with a left hip fracture. Findings include: According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Rev. 229, Issued: 04/25/25 supervision is an intervention and a means of mitigating accident risk. Facilities are obligated to provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Devices such as position change alarms may help to monitor a resident's movement temporarily, but do not eliminate the need for adequate supervision. Position change alarms are not prohibited from being included as part of a plan, they should not be the primary or sole intervention to prevent falls. If facility staff choose to implement alarms, they should document their use aimed at assisting the staff to assess patterns and routines of the resident. Use of these devices, like any care planning intervention, must be based on assessment of the resident and monitored for efficacy on an on-going basis. Position change alarms have been used to monitor a resident's movement in chairs or beds, etc. However, there must be sufficient staff and supervision to meet the resident's needs and staff must be vigilant in order to respond to alarms in a timely manner. Alarms do not replace necessary supervision. Facilities must take steps to identify issues that place the resident at risk for falls and implement approaches to address those risks in a manner that enables the resident to achieve or maintain their highest practicable physical, mental, and psychosocial well-being. R1's nursing order dated 3/29/24 at 2:26 p.m. indicated R1 had a fall alarm on her wheelchair and in her bed due to repeated falls. The order was open ended. The alarms were to be checked three times a day, a.m., p. m., and at the hour of sleep (HS). R1's care plan dated 4/2/24 indicated R1's problem was safety/falls indicating she was at risk for falls and injuries as evidenced by unsteady gait and balance, need for assistance to transfer on and off the toilet, recent emergency department visit, use of assistive devices, cognitive status, history of falls. R1 was taking Donepezil (for treatment of dementia), risperidone (anti-psychotic), and sertraline (anti-depressant). She had diagnoses of fracture of the fifth metatarsal bone of the left foot, generalized anxiety and imbalance. Interventions were: Wander guard to ankle to alert staff if she left the building Adequate bed height Adequate lighting Call light in reach Clear path to the bathroom Clothing fits properly Complete an incident report for any falls or injuries Consult with registered nurse (RN) supervisor as needed Electrical cords and call light cords in proper placement Equipment in good repair Floor clean and dry Furniture in adequate placement Hallways free of clutter Notify family member and medical doctor (M.D.) if an incident report is completed Proper non-slip footwear when not in bed Report any confusion or light headedness to charge nurse Report any indication of pain or unsteadiness to charge nurse Room free of clutter The following alarms were in place - bed and chair sensor alarm Safety risk and physical device assessment quarterly and as needed (PRN) R1's care plan failed to provide any interventions of staff supervisor for R1 to reduce the risk of falls. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 8 indicating R1 was cognitively impaired. R1's mobility devices used were a walker and a wheelchair. She required maximum assistance with toileting hygiene, showering, lower body dressing and walking. She required moderate assistance with upper body dressing, sitting to standing and transferring from chair to bed/bed to chair. R1 was frequently incontinent of urine and bowel. Her pertinent diagnoses were nondisplaced fracture of the fifth metatarsal bone left foot, open-angle glaucoma, age related osteoporosis. R1 used a bed alarm, chair alarm, and a wander/elopement alarm daily. R1's incident report dated 11/15/25 at 2:08 p.m. indicated R1 had a fall in the bathroom. The evaluation details indicated the root cause was R1 was a fall in her room due to the alarm on her chair was not turned on. R1 was transferred from the toilet in a different room. Staff flipped the alarm switch off when getting her to the toilet. A staff member was passing water and found R1 on the floor. The immediate intervention was R1 was sent to the emergency department (ED) due to hip pain. She was found to have a left femur fracture. The intervention on her hospital return was the sensor alarm was changed to one that automatically comes on. Staff education was completed to remind staff to make sure alarms are in place and</p>		