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	02/26/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 6 of 6 resident rooms (R9, R11, R16, R28, R31, R32,) tested for safe water temperatures. This deficient practice had the potential to affect all 6 residents who used water from the water faucets. Findings include: On 2/24/25 at 11:00 a.m., during resident screening the water temperatures in R9, R11, R16, R28, R31, and R32's rooms felt very warm to the touch after running water for one minute. During an observation and interview on 2/24/25 at 11:28 a.m., maintenance director (MD) verified the water in R9, R11, R16, R28, R31 and R32's room felt too hot and used the facility digital thermometer to measure the water temperatures in resident rooms. Water temperatures were as follows: -R9's room [ROOM NUMBER] was 129 degrees F. -R11 room [ROOM NUMBER] was 129 degrees F. -R16 room [ROOM NUMBER] was 129 degrees F. -R28 room [ROOM NUMBER] was 129 degrees F. -R31 room [ROOM NUMBER] was 130 degrees F. -R32 room [ROOM NUMBER] was 126 degrees F. During an interview on 2/24/25 at 11:52 a.m., R24 stated the water in his room was too hot and he had to turn the cold water on or he would have burned his hands. During an interview on 2/2/25 at 2:29 p.m., R31 stated the water in his room gets hot when it runs for a while. During an interview on 2/24/25 at 3:19 p.m., R11 stated the water in her room gets too hot. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25 at 2:02 p.m., registered nurse (RN)-A verified all six residents were at risk for potential burns when the water was too hot. During an interview on 2/25/25 at 2:45 p.m., MD verified the above rooms were too hot according to State and Federal guidelines. MD stated he had completed random audits of water temps in the past month. MD stated they purchased a new hot water heater in the past few months which could have affected the water temperatures. MD stated his expectation was that the water temperatures in all resident rooms would remain between 105 and 115 degrees to prevent burns. During an interview on 2/25/25 at 2:19 p.m., administrator stated his expectations were that the water temperatures would remain within the State and Federal guidelines to prevent burns. Review of a facility policy titled Water Management Plan for Legionella updated 10/8/24, identified the facility was required to follow anti-scalding guidelines. Policy identified the water accessible to residents was between 105 and 115 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview, and document review, the facility failed to implement donning/doffing of personal protective equipment (PPE) practices for 2 of 2 residents (R32 and R16) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to ensure hand hygiene while providing personal cares to prevent the spread of infections for 1 of 3 residents (R30) observed during cares. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of PPE use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. EBP R32 R32's significant change Minimum Data Set (MDS) dated [DATE], identified R32 had moderate cognitive impairment and diagnoses which included heart failure, dementia, and arthritis. Identified R32 required extensive assistance for activities of daily living (ADL's) which included toileting, transfer, and dressing. Indicated for ADL's which included toileting, transfer, and dressing. Indicated. Indicated R32 had a pressure ulcer. R32's care plan revised 1/20/25, indicated R32 R32 had an unstageable pressure ulcer to her sacral area. Care plan instructed staff to use Enhanced Barrier Precautions related to R32 being at risk for developing a Multi Drug Resistant Organism (MDRO) infection. R32's weekly wound assessment dated [DATE], identified R32 had an open pressure wound on her left buttocks that measured 1 inch in length and 1 inch in width with a moderate amount of serosanguinous (clear and bloody) drainage. Assessment identified that a calcium alginate dressing was applied over the wound. During an observation on 2/24/25 at 10:55 a.m., there was a plastic bin with three drawers placed on the floor in R32's room near the bed. Additionally, there was a sign on R32's room door that said Enhanced Barrier Precautions; Everyone Must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer, gown, and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/25/25 at 9:57 a.m., hospice aide (HA)-A entered R32's room wearing a surgical mask, sanitized hands, put soap and water into a basin, put gloves on and proceeded to place a washcloth into the wash basin and used the wash cloth to clean R32's face. HA-A then removed another washcloth from the wash basin and washed the front side of R32's perineal area with the washcloth. HA-A placed the washcloths into a plastic bag. HA-A removed her gloves, sanitized her hands and removed R32's gown and placed a clean gown on R32. HA-A combed R32's hair and adjusted the boots to R32's feet. HA-A covered R32 up with a sheet and sanitized her hands. HA-A was not wearing a gown at any time during this observation. During an interview on 2/25/25 at 10:20 a.m., HA-A stated she was aware R32 had a pressure ulcer on her buttock. HA-A stated she was not required to wear a gown while caring for R32 unless she was assisting the nurse with wound care. HA-A stated she was unaware she should have been wearing a gown while providing personal cares to R32. During an observation on 2/25/25 at 11:21 a.m., nursing assistant (NA)-B entered R32's room sanitized hands, applied gloves and assisted R32 to roll onto her side by placing her left hand on R32's back while using her right hand to remove R32's soiled brief. NA-B used a wipe to wipe R32's perineal area from front to back, removed the gloves, sanitized her hands and placed the a clean brief on R32. NA-B took a mouth swab out of the bedside table and swabbed R32's mouth out with the swab. NA-B was not wearing a gown at any time during this observation. During an interview on 2/25/25 at 11:26 a.m., NA-B stated she was not required to wear a gown while providing cares to R32 unless she was assisting the nurse with wound care. NA-B stated she was unaware she should have been wearing a gown while providing personal cares to R32. 37905 R16 R16's significant change MDS dated [DATE], identified R16 had severe cognitive impairment with diagnoses which included, Alzheimer's disease, heart failure, and anxiety. Identified R16 required substantial/maximal assistance with shower/bathing and upper body dressing, and was dependent for lower body dressing and transfers. R16's care plan revised 2/18/25, identified R16 had ADL self care deficit and needed assistance to complete ADLs. R16 required EBP, related to: open draining wounds to right lower extremity and was at risk of developing a multi-drug resistant organism/infection. Interventions included apply personal protective equipment (PPE) prior to providing wound care. Remove before leaving R16's room. R16's care plan lacked EBP intervention to include use of PPE with all high contact resident care activities. R16's Referral Form signed 2/7/25, included order: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-wound on right leg-cleanse wound with wound cleaner, apply collagen (wound gel to promote healing) to wound beds, apply non-adherent super absorbent dressing. Wrap with Kerlix (gauze dressing in a roll). During an observation on 2/24/25 at 5:33 p.m., NA-D assisted R16 back to her room in her wheelchair. R16's door had a CDC EBP sign on the door, which identified providers and staff must wear gloves and a gown for the following high-contact resident care activities, which included dressing. R16 stated she was hot, so NA-D assisted R16 to remove her long sleeve shirt, and applied a short sleeve shirt. NA-D asked R16 if she was comfortable and R16 agreed. NA-D placed R16's long sleeve shirt in her lap as R16 requested, In case I get cold. then NA-D assisted R16 back to the dining room. NA-D did not apply PPE while assisting R16 with dressing. During an observation on 2/25/25 at 2:03 p.m., R16 NA-C answered R16's call light, who requested to go to the bathroom. NA-C informed she would get assistance and be right back. At 2:06 p.m. NA-C and NA-B entered R16's room, applied gloves and assisted R16 to transfer to a commode brought from the bathroom. NA-C and NA-B waited in the room, allowed R16 time to use the commode, assisted R16 to stand, provided perineal cares and assisted her back into her recliner. NA-C and NA-B did not wear a gown, as directed for EBP with high contact cares including transferring and assisting with toileting. During an interview on 2/25/25 at 2:15 p.m., NA-B confirmed R16 had a dressing on her right leg. NA-B indicated the nurses wore PPE when they changed R16's dressing on her wound. NA-B stated the nursing assistants did not wear PPE when they assisted R16 with cares. NA-B indicated the only time they would wear a gown was if they were assisting the nurse with changing R16's dressing or if the dressing came off. 48740 HAND HYGIENE R30's quarterly MDS dated [DATE], identified R30 as having intact cognition, and was diagnosed with depression, dementia, and heart failure. R30 needed maximal assistance with transfers and moderate assistance for ADL's which included toileting, and dressing. R30's care plan revised on 1/31/25, identified R30 needed assistance for dressing and assist of one with the PAL (mechanical standing lift to assist a person from sitting to standing) for toileting and transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/26/25 at 7:20 a.m., NA-E applied gloves, retrieved a warm washcloth and hand towel and prompted R30 to wash her face. R30 was sitting on the side of the bed. NA-E put on a clean brief and applied pants up to R39's knees. NA washed R30's back, arms, underarms, and under her breasts. NA-E applied lotion to R30's back, arms, and chest. NA-E put a bra, shirt, and sweater on R30. NA-E warmed the washcloth in warm water and placed the washcloth on the hand towel on the side table. NA-E applied the mechanical lift sling around R30, hooked R30 to the mechanical standing lift and assisted R30 to stand. NA-E took off the brief R30 was wearing the previous night. NA-E took the warm washcloth and provided perineal hygiene care. NA-E took the hand towel and dried R30 perineal area. NA-E did not remove gloves and proceeded to pulled up R30's clean brief and pants. NA-E adjusted R30's shirt and moved the mechanical standing lift toward the wheelchair. NA-E positioned the wheelchair behind the resident, NA-E pressed the down button on the mechanical standing lift, lowering R30 until sitting in the wheelchair. NA-E removed the mechanical lift sling from R30 and placed the sling on the mechanical standing lift. NA-E unhooked the bed sensor alarm from the bed and hooked the sensor alarm to the wheelchair. NA-E pushed R30 up to the sink, opened the cupboard, and took out R30's toothpaste and toothbrush. R30 requested NA-E to put her phone charger in a basket away from the sink, which NA-E did. NA-E then took R30's hairbrush and brushed R30 hair and gave R30 her glasses, which R30 applied herself. NA-E then removed gloves and pushed R30 to the door and applied R30's foot pedals to the wheelchair. NA-E pushed R30 to the living room area. During an interview on 2/26/25 at 7:50 a.m., NA-E verified she did not remove her gloves after perineal care. NA-E verified she proceeded to touch other items in the room such as her toothbrush and hair brush. NA-E verified she should have removed her gloves after perineal care and before touching other items in the room. During an interview on 2/26/25 at 8:40 a.m., NM-A indicated her expectation was to have staff apply gloves before and remove aftercare. NM-A stated staff should wash hands and apply gloves when walking into a room, and remove gloves after cares, and wash hands. During an interview on 2/25/25 at 1:23 p.m., infection preventionist (IP) verified R32 and R16 had chronic wounds which required a dressing. IP stated her understanding was that staff only had to wear a gown while caring for a resident with chronic wounds if they were directly working with the wound. IP stated her expectation going forward was for staff to wear all of the proper PPE which included a gown while caring for any residents on EBP to prevent the spread of infection. During an interview on 2/26/25 at 8:43 a.m., the IP indicated after staff was done with the soiled part of the perineal cares, staff should remove gloves, wash their hands before applying a clean brief and apply clean gloves before applying creams. During an interview on 2/25/25 at 4:07 p.m., director of nursing (DON) verified R32 and R16 had open wounds with dressings and required EBP. DON stated her expectation was that staff would have followed EBP per CDC guidelines to prevent the spread of infection. Review of a facility policy titled Enhanced Barrier Precautions dated 11/3/23, identified the facility was to follow the direction of federal and state agencies regarding the Enhanced Barrier Precautions and preventing MDRO spread. Identified staff were to use gown and gloves during high -contact resident care activities which included: dressing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care-central line urinary catheter, feeding tube, wound care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Started Precautions dated 5/21/06 identified 2) Gloves - wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another resident, and wash hands immediately. Review of the policy titled Hand Hygiene Policy and Procedure dated 11/18/15 revealed 2. Change gloves during patient care if moving from a contaminated body site to a clean body site. 3. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient.