DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 31, 2025

Licensee
Clara City Assisted Living
200 East Wachtler Avenue
Clara City, MN 56222

RE: Project Number(s) SL31473016

Dear Licensee:

On December 22, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 17, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

Electronically Delivered

November 14, 2025

Licensee
Clara City Assisted Living
200 East Wachtler Avenue
Clara City, MN 56222

RE: Project Number(s) SL31473016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31473	A. BUILDING: _____ B. WING _____	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 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) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31473016-0 On October 13, 2025, through October 17, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 22 residents; 22 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was issued at a level 3/Widespread (I). The licensee took immediate action to mitigate risk; however, the scope and level remain at I. 2310: An immediate correction order was issued at a level 3/Isolated (G). The licensee took immediate action to mitigate risk; however, the scope and level remain at G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 550	Continued From page 1	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed have all the required contact in the posted grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 2 The findings include: On October 13, 2025, at 10:30 a.m. upon entering the facility, the surveyor observed a folder labeled grievance, on a desk area near the entrance to the facility. In the folder, was a document titled How to Submit a Complaint about Our Assisted Living Services dated July 24, 2019. The document included the name and address of the administrator and the name, address, and phone number for an RN no longer employed at the facility. The document failed to include the following required content: - the phone number and email for the administrator, - contact information for Office of Ombudsman for Mental Health and Developmental Disabilities - information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On October 13, 2025, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was unaware the grievance posting did not have the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:	0 640		

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0 640	Continued From page 3 (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and information for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at 10:30 a.m. upon entering the facility, the surveyor observed a posting in a picture frame in the entryway that included the address and phone number for MAARC along with other agency contact information. The posting did not include information related to reporting suspected	0 640		

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0 640	Continued From page 4 maltreatment to MAARC or to call 911 in an emergency as required. On October 13, 2024, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated there was no information for reporting abuse to MAARC and 911 for emergency was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 5 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to prominently post the EPP. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at 10:30 a.m. upon entering the facility, the surveyor observed a folder on the front desk area labeled Emergency Plan. The folder included an undated, two page document titled Emergency Preparedness Plan Fact Sheet. The document included generic information identifying the facility had an EPP, had a vulnerability assessment to determine risk to the facility, residents and staff were educated and the plan was updated annually. The document indicated the facility had arrangements with other facilities, residents would be sent with information if evacuated, and the family would be contacted. The folder also included facility maps.	0 680		

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0 680	Continued From page 6 The document did not include any policies or procedures related to EPP. The licensee's Emergency Preparedness and Communications Plan updated October 8, 2025, lacked evidence of the following required content: - Missing Resident policy was last reviewed May 29, 2024, and was not reviewed quarterly as required; - A policy/procedure to track the location of on-duty staff and sheltered residents; - A policy/procedure to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; and - A policy to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act. On October 16, 2025, at 12:48 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the missing person plan was reviewed annually during staff meetings; as they were unaware it needed to be reviewed quarterly. LALD-A further stated the emergency plan lacked the above noted required content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall	0 700		

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0 700	Continued From page 7 establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of both electronic and written records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 13, 2025, at 12:04 p.m., unlicensed personnel (ULP)-C set up medications for R6. At 12:09 p.m., ULP-D left the medication cart in a hallway with a laptop computer sitting open on top of the medication cart, and entered R6's room. The laptop had resident identifying information and medication information on the screen and was visible to any staff, residents, or visitors who walked past. ULP-D administered medications to R6. ULP-D returned to the medication cart at 12:12 p.m. On October 14, 2025, at 7:16 a.m., ULP-J set up R6's medications for administration. ULP-J left	0 700		

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0 700	Continued From page 8 the medication cart in a hallway with the laptop screen open to R6's medication record and entered R6's room. The laptop was visible to any staff, residents, or visitors who walked through the hallway. ULP-J administered oral medications, eye drops and visited briefly with R6 and then returned to the medication cart. On October 14, 2025, at 9:05 a.m., ULP-B assisted a resident to the bathroom. A laptop computer was on a medication cart, in a common area of the memory care unit and residents were wandering in the area. The laptop computer was open with several residents and their services listed on the screen. At 9:14 a.m., ULP-G entered the common area where the laptop and medication cart was and left the area at 9:17 a.m. with the screen still open and visible. At 9:21 a.m., ULP-B returned to the area, washed her hands and was standing by the medication cart again. On October 15, 2025, at 10:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the computer screens should be closed or the screen locked when staff walk away, to protect the resident medical records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 775		

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0 775	Continued From page 9 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on October 16, 2025, from 9:18 a.m. through 10:12 a.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and maintenance supervisor (MS)-K, the surveyor observed emergency exit doors in memory care with exit signs above them that were equipped with magnetic locks that required a code to unlock. The same style lock was observed on the door to the care center and on an exterior door. The surveyor did not observe a button or switch that would deactivate the locks. MS-K stated they were not aware of a switch in the building that would deactivate the locks. The locks were not capable of being deactivated by a signal or switch located in an approved location as required in State Fire Code in Minnesota Rules, chapter 7511.	0 775		

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0 775	Continued From page 10 LALD/CNS-A and MS-K verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-D). In addition, the licensee failed to ensure a background study was affiliated with this licensee's health facility identification (HFID) 31473 for seven of seven	01290		

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CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 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) COMPLETE DATE
01290	Continued From page 11 employees (ULP-G, ULP-B, ULP-J, ULP-C, ULP-F, ULP-H, ULP-I). This resulted in an immediate order on October 14, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at 1:52 p.m. licensed assisted living director (LALD)-A stated the human resources personnel at the nursing home managed the background studies. The background studies were completed for the nursing home HFID 61. LALD-A stated she was unaware the background studies needed to be affiliated to the assisted living license HFID 31473. LALD-A further stated all ULP provided unsupervised direct care. ULP-D ULP-D was hired on March 29, 2005, and began providing assisted living services to the facility's residents on August 1, 2021. The facility's schedule dated September 29, 2025, through October 12, 2025, indicated ULP-D worked September 30, 2025, October 1, 3, 11, 12, 2025. ULP-D's employee record included a Background Study Clearance dated September 3, 2018, for HFID 31555 (the licensee's Comprehensive	01290		

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01290	Continued From page 12 Home Care which closed with Assisted Living licensure on August 1, 2021. DHS NETStudy 2.0 identified ULP-D had a background study dated August 22, 2018, for HFID 31555, with a separation date of December 12, 2021. DHS NETStudy 2.0 roster for HFID 61, did not include ULP-D. DHS NETStudy roster for HFID 31473, did not include ULP-D. Affiliation ULP-G ULP-G was hired on February 25, 2025, and provided direct care services to the residents. On October 14, 2025, at 7:31 a.m. the surveyor observed ULP-G applying compression stockings on R2. ULP-G was working unsupervised. DHS NETStudy 2.0 identified ULP-G had a background study dated February 17, 2025, for HFID 61. DHS NETStudy roster for HFID 31473, did not include ULP-G. ULP-B ULP-B was hired on August 27, 2021, and provided direct care to the facilities residents. On October 13, 2025, at 11:10 a.m., the surveyor observed ULP-B working independently and administering medications to a resident. DHS NETStudy 2.0 identified ULP-B had a background study dated June 28, 2017, for HFID 61. DHS NETStudy roster for HFID 31473, did not include ULP-B.	01290		

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01290	Continued From page 13 ULP-J ULP-J was hired on May 8, 2023, and provided direct care services to the residents. On October 14, 2025, beginning at 7:14 a.m. until 8:06 a.m., the surveyor observed ULP-J working independently and administering medications to the residents. DHS NETStudy 2.0 identified ULP-J had a background study dated December 13, 2013, for HFID 61. DHS NETStudy roster for HFID 31473, did not include ULP-J. ULP-C ULP-C was hired on June 19, 2012, and began providing assisted living services on August 1, 2021. On October 13, 2025, at 12:04 p.m., the surveyor observed ULP-C working independently and administering medications to a resident. DHS NETStudy 2.0 identified ULP-C had a background study dated May 28, 2015, for HFID 61. DHS NETStudy did not include an affiliation of ULP-C to HFID 31473. ULP-F ULP-F was hired on October 1, 2000, and began providing services under the assisted living licensure on August 1, 2021. The facility's schedule dated September 29, 2025, through October 12, 2025, indicated ULP-F worked September 30, 2025, October 1, 2, 3, 5, 6, 8, 9, 2025. DHS NETStudy 2.0 identified ULP-F had a	01290		

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01290	Continued From page 14 background study dated October 19, 2000, for HFID 61. DHS NETStudy did not include an affiliation of ULP-F to HFID 31473. ULP-H ULP-H was hired on April 29, 2025, and provided direct care services to the residents. The facility's schedule dated September 29, 2025, through October 12, 2025, indicated ULP-H worked September 30, 2025, October 3, 4, 5, 6, 7, 9, and 10, 2025. DHS NETStudy 2.0 identified ULP-H had a background study dated January 23, 2025, for HFID 61. DHS NETStudy did not include an affiliation of ULP-H to HFID 31473. ULP-I ULP-I was hired on July 15, 2025, and provided direct care services to the residents. The facility's schedule dated September 29, 2025, through October 12, 2025, indicated ULP-I worked September 29 and 30, 2025, October 1, 4, 5, 7, and 8, 2025. DHS NETStudy 2.0 identified ULP-I had a background study dated July 1, 2025, for HFID 61. DHS NETStudy did not include an affiliation of ULP-I to HFID 31473. On October 13, 2025, at 3:02 p.m., LALD-A stated all staff should have had a background study completed. The licensee's background checks policy dated May 31, 2024, included "All employees; as well as contractors, and regularly scheduled	01290		

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01290	Continued From page 15 volunteers of the facility with direct resident contact will undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and it's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On October 14, 2025, the licensee took action to mitigate immediate risk; however, the scope and level remains at I.	01290		
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01320		

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01320	Continued From page 16 review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care by one of two unlicensed personnel (ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J was hired on May 8, 2023, and provided direct care services to the residents. On October 14, 2025, at 7:14 a.m., the surveyor observed ULP-J administering medications to residents. ULP-J's employee record lacked evidence ULP-J had been trained in the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (6) training on the prevention of falls; and (8) medication, exercise, and treatment reminders. On October 17, 2025, at 12:31 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff should have had all the required trainings and competencies.	01320		

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01320	Continued From page 17 The licensee's Assisted Living Orientation - ULP Staff dated July 22, 2025, indicated all staff would be trained including the following: - Documentation requirements for services provided; - Changes of condition - Observation - How and where to report; - Fall prevention; - Medication reminders; - Exercise reminders; and - Treatment reminders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01320		
01330 SS=E	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.	01330		

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01330	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care by two of two unlicensed personnel (ULP-G and ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-G ULP-G was hired on February 25, 2025, and provided direct care services to the residents. On October 14, 2025, at 7:31 a.m., the surveyor observed ULP-G putting TED (thrombo embolic deterrent) stockings (used to decrease swelling and increase circulation) to R2. ULP-G employee record lacked evidence ULP-G had been trained or competency tested for range of motioning and positioning. ULP-J ULP-J was hired on May 8, 2023, and provided direct care services to the residents.	01330		

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01330	Continued From page 19 On October 14, 2025, at 7:14 a.m., the surveyor observed ULP-J administering medications to residents. ULP-J's employee record lacked evidence ULP-J had been trained and/or competency tested in the following: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; and (5) safe transfer techniques. On October 17, 2025, at 12:31 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff should have had all the required trainings and competencies. The licensee's Assisted Living Orientation - ULP Staff dated July 22, 2025, indicated all staff would be trained including the following: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - safe transfer techniques and ambulation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01330		

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01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500		

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01500	Continued From page 21 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J was hired on May 8, 2023, and provided	01500		

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01500	Continued From page 22 direct care services to the residents. On October 14, 2025, at 7:14 a.m., the surveyor observed ULP-J administering medications to residents. ULP-J's employee record lacked evidence ULP-J had completed person centered care training annually. On October 17, 2025, at 12:31 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff should have had all the required trainings and competencies. The licensee's Assisted Living with Memory Care Annual Training dated July 22, 2025, would include principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and	01540		

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01540	Continued From page 23 who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of two employees (unlicensed personnel (ULP)-J and ULP-G). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-G ULP-G was hired on February 25, 2025, and provided direct care services to the residents.	01540		

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01540	Continued From page 24 On October 14, 2025, at 7:31 a.m., the surveyor observed ULP-G putting TED (thrombo embolic deterrent) stockings (decreases swelling and increases circulation) onto R2's lower extremities. ULP-G's employee record lacked evidence ULP-G had completed two hours of training on topics related to mental illness and de-escalation ULP-J ULP-J was hired on May 8, 2023, and provided direct care services to the residents. On October 14, 2025, at 7:14 a.m., the surveyor observed ULP-J administering medications to residents. ULP-J's employee record lacked evidence ULP-J had completed two hours of training on topics related to mental illness and de-escalation On October 17, 2025, at 12:31 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff had not completed mental illness and de-escalation training. LALD/CNS-A further stated the training had been assigned in the electronic training system and was to be completed by the staff by the end of the year. The licensee's Assisted Living with Memory Care Dementia Training dated July 22, 2025, did not include mental illness and de-escalation training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

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01620	Continued From page 25	01620		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 56222

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01620	Continued From page 26 review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment at least every 90 days as required for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 was admitted on March 5, 2024, and received assisted living services.	01620		

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01620	Continued From page 27 On October 14, 2025, at 9:22 a.m., the surveyor observed ULP-B administering medication to R3. On October 16, 2025, at 11:16 a.m., ULP-C stated R3 had significant behavioral issues and showed the surveyor a behavioral management task on her tablet. R3's service plan signed dated March 5, 2024, indicated R3's services included dressing, grooming, bathing, medication management and administration. R3's service plan did not include behavior management. R3's record included the following assessments: - May 20, 2025, Change of Condition; and - August 19, 2025, 90-day assessment; this was 91 days between assessments, thus exceeding 90 calendar days. R4 R4 was admitted on June 5, 2025, and received assisted living services. On October 15, 2025, at 8:06 a.m., the surveyor observed ULP-J administering medications to R4. R4's service plan dated August 20, 2024, indicated R4's services included dressing, grooming, bathing, medication administration, and blood glucose monitoring. R4's record included the following assessments: - February 16, 2025, 90-day assessment; - May 19, 2025, 90-day assessment; this was 92 days between assessments; and - August 19, 2025, 90-day assessment; this was	01620		

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01620	Continued From page 28 92 days between assessments, thus both assessments exceeding 90 calendar days. On October 17, 2025, at 12:31 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all assessments should have been completed at least every 90 days. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency dated July 22, 2025, identified "Ongoing monitoring and review will be conducted as needed based on changes in the resident needs and will not exceed 90 calendar days from the last review date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640		

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01640	Continued From page 29 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for two of four residents (R5, R7) and failed to ensure a written service plan was revised to reflect the current services provided for two of two residents (R7, R3) who had changes in services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5 was admitted on June 3, 2025, with diagnoses including metabolic encephalopathy (brain does not function properly due to an underlying metabolic disorder) and neuropathy	01640		

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01640	Continued From page 30 (nerve pain). On October 14, 2025, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-J administering medications to R5 R5's service plan was signed October 15, 2025, after requested by the surveyor, and indicated R5's services included bathing, dressing, grooming, catheter care, and medication administration. R5's record lacked evidence of a signed service plan prior to the start of the survey. R7 R7 was admitted on November 16, 2023, with a diagnosis of Alzheimer's disease. On October 16, 2025, at 11:24 a.m., the surveyor observed ULP-C assisting R7 ambulate to her room and assist her into bed. R7's service plan was signed October 16, 2025, after requested by the surveyor, and indicated R7's services included bathing, dressing grooming, behavior management, and medication administration. A signed service plan prior to October 16, 2025, was requested and was not provided. R3 R3 was admitted on March 5, 2024, with diagnoses including dementia and encephalopathy (a disease of the brain). On October 14, 2025, at 9:22 a.m., the surveyor observed ULP-B administering medication to R3. On October 16, 2025, at 11:16 a.m., ULP-C	01640		

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01640	Continued From page 31 stated R3 had significant behavioral issues and showed the surveyor a behavioral management task on her tablet. R3's service plan signed on March 5, 2024, indicated R3's services included dressing, grooming, bathing, medication management and administration. R3's service plan did not include behavior management. R3's documentation of services dated October 2025, indicated R3's services included behavior management for agitation. R3's progress notes dated May 20, 2025, indicated the following: - facility initiated behavior charting on March 31, 2025, and had some medication changes; - On May 2, 2025, the facility discussed an inpatient behavioral health hospitalization due to "continued behaviors surrounding care and staff not being able to provide care due to the behaviors"; - On May 15, 2025, she was sent to the emergency room for a mental health crisis. When staff were providing cares R3 hit staff in the face hard enough to cause injury and medical attention for the staff; - On May 17, 2025, R3 returned to the facility and had psychotropic medication changes; - On May 20, 2025, a change in condition assessment was completed; - On May 22, 2025, R3 was transferred to a behavioral health unit; - On June 18, 2025, R3 returned to the facility. Resident had several physically aggressive behavioral incidents, personal care refusal behaviors and medication changes. - On September 4, 2025, R3 was admitted to	01640		

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01640	Continued From page 32 hospice and a significant change assessment had been completed. On October 15, 2025, at 11:44 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R5 did not have a signed service plan. At 2:42 p.m., LALD/CNS-A stated R3's service plan was the most current signed service plan and a new service plan was not signed when behavior management started or when the resident began hospice services. At 1:15 p.m., LALD/CNS-A stated R7's service plan had been updated with new services since the signed service plan and therefore an updated one was printed and sent to a family member to be signed. The licensee's Contents of Service Plans policy dated July 22, 2025, indicated service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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01890	Continued From page 33 Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the open date and/or expiration date and failed to ensure medications were stored according to manufacturer recommendations in one of two medication carts. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 13, 2025, at 11:15 a.m., the surveyor observed a medication cart with ULP-C. The following were observed in the medication cart: - Ventolin HFA inhaler open and in use - there was no open date identified on the the inhaler or the box. The pharmacy label indicated it expired on July 15, 2025. - calcitonin nasal spray did not contain an open date and was laying on its side in the drawer. On October 13, 2025, at 2:36 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the Ventolin inhaler and calcitonin nasal spray should have had an open date on them, the expired Ventolin should have been removed from the cart after expiration, and the calcitonin should have been stored upright according to manufacturer recommendation.	01890		

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01890	Continued From page 34 Ventolin's prescribing information dated December 2014, identified the inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture-protective foil pouch, whichever comes first. Miacalcin (calcitonin) nasal spray prescribing information dated September 2017, identified the following: "Store open bottles of Miacalcin at room temperature between 59°F (Fahrenheit) to 86°F (15°C (Celcius) to 30°C) for 35 days. Store Miacalcin bottles in an upright position." The licensee's Storage of Medications policy dated July 22, 2025, indicated medications would be stored consistent with manufacturer instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and	02310		

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02310	Continued From page 35 services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with hospital bed rails. This resulted in an immediate correction order on October 15, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included dementia and encephalopathy (any diffuse disease of the brain that alters brain function). R3's Service Plan dated March 5, 2024, indicated R3 received assistance with bathing, dressing, grooming, medication management and administration, and safety checks. On October 15, 2025, at 12:32 p.m., the surveyor observed a hospital bed with bilateral upper half rails in the down position in R3's room. On October 15, 2025, at 12:32 p.m., unlicensed personnel (ULP)-B stated R3 received the hospital bed about a month ago. R3's Resident Notes dated September 4, 2025, indicated hospice was going to order R3 a hospital bed. R3's resident notes also included episodes of physical aggression and hospitalizations for behavior management.	02310		

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02310	Continued From page 36 R3's Resident Profile printed on October 14, 2025, indicated R3 received behavior management assistance for agitation in addition to services of bathing, dressing, grooming and medication administration. R3's comprehensive assessment dated September 4, 2025, indicated R3 was admitted to hospice services resulting in a change in condition. The assessment indicated R3 was independent with bed mobility and had a standard bed. The assessment did not identify R3 had a hospital bed with side rails, an assessment for appropriate use of the rails, or measurements to assure the safety zones were within the guidelines On October 15, 2025, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated hospice had ordered the hospital bed when R3 admitted to hospice last month. LALD/CNS-A stated the September 4, 2025, assessment was the most current assessment and she had not completed a side rail assessment for R3. The licensee's Device and Device Assessment policy indicated: 1. Due to the risk of injury related to the use of physical devices, such devices will only be used after an assessment has been completed to determine the risks and benefits of this use. 2. The resident/responsible party will be educated regarding the risks and benefits of physical devices. Physical devices will be reviewed for safety and used according to manufacturer's recommendations. 3. Continued use of physical devices will be	02310		

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02310	Continued From page 37 assessed at least every 90 days or with significant change to determine if the device is still needed to enhance the resident's safety and/or bed mobility. 4. If the physical device restricts a resident's freedom of movement, it constitutes a restraint, and our facilities are restraint free. Physical devices that do not restrict the resident's freedom of movement and are used to assist the resident/client in bed mobility are not restraints. 5. Physical devices include, but are not limited to, side rails (half or full); grab bars, halo bars, positioning poles." "1. If the resident expresses the desire to use a device or a device is in use/recommended, a nurse will complete a device assessment at the time of move in, upon hospital return, change in condition, and / or upon discovery of a rail. 2. The licensed nurse or designee will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. 3. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Device will be installed per FDA guidelines." "The FDA recommends that the dimensions in Zones 1-4 be less than: Zone I: Within the Rail (4.75") Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support (4.75") Zone 3: Between the Rail and the Mattress (4.75") Zone 4: Under the Rail, at the Ends of the Rail (2 and 3/8" and greater than 60° angle)" The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone	02310		

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02310	Continued From page 38 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail;	02310		

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CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 56222

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02310	Continued From page 39 - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took immediate action to mitigate risk; however, the scope and level remains at G.	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31473	A. BUILDING: _____ B. WING _____	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 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) COMPLETE DATE
02320	Continued From page 40 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure medications were administered according to policy and accepted standards of practice for one of one resident (R5) with diclofenac gel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was admitted on June 3, 2025, and diagnoses included metabolic encephalopathy (brain does not function properly due to an underlying metabolic disorder) and neuropathy (nerve pain). R5's service plan signed October 15, 2025, after requested by the surveyor, indicated R5's services included medication administration. R5's physician orders dated June 9, 2025, included diclofenac 1% gel apply 4 grams to affected area every morning and bedtime. R5's September 2025, MAR included diclofenac 1% gel apply 4 grams to affected area every morning and bedtime (resident will tell you where it is to be applied.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31473	A. BUILDING: _____ B. WING _____	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 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) COMPLETE DATE
02320	Continued From page 41 On October 14, 2025, at 8:00 a.m., unlicensed personnel (ULP)-J administered R5's diclofenac gel from the medication cart, entered R5's room, squeezed some of the gel onto her gloved hand and applied to R5's right knee, squeezed some more diclofenac gel onto her gloved hand and applied to R5's left knee. ULP-J did not use the manufacturer's measuring strip to measure the diclofenac gel. On October 15, 2025, at 10:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff had been trained to use the measuring strip provided by the manufacturer when administering the diclofenac, so they would administer the correct dosage. The Voltaren (diclofenac) gel instructions for use dated revised May 2016, identified to use the dosing card to correctly measure each dose. Place the dosing card on a flat surface so that you can read the print. Squeeze the gel onto the dosing card evenly, up to the 2-gram line (a 2.25-inch length of gel) or 4-gram line (a 4.5 inch length of gel). Make sure that the gel covers the 2-gram or 4-gram area of the dosing card. After using the dosing card, hold end with fingertips, rinse and dry. Store the dosing card until next use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31473	A. BUILDING: _____ B. WING _____	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 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) COMPLETE DATE
03090	Continued From page 42 entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at 10:30 a.m. upon entering the facility, the surveyor observed there was no electronic monitoring notice posted on or by the entrance to the facility. On October 13, 2025, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated there had been the required signage posted and she was unsure what happened to it.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31473	A. BUILDING: _____ B. WING _____	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA CITY ASSISTED LIVING	200 EAST WACHTLER AVENUE CLARA CITY, MN 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) COMPLETE DATE
03090	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

CLARA CITY ASSISTED LIVING
200 EAST WACHTLER AVENUE
Clara City, MN 56222
Chippewa County
Parcel:

Phone:

License Info

License: HFID 31473

Risk:
License:
Expires on:
CFPM: Sara Peterson
CFPM #: 119515; Exp: 9/30/2026

Inspection Info

Report Number: F7935251155
Inspection Type: Full - Single
Date: 10/16/2025 Time: 10:07:45 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Fergus Falls District Office inspection report number F7935251155 from 10/16/2025

Rebecca Tonneson

Establishment Representative

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

CLARA CITY ASSISTED LIVING
Clara City
County/Group: Chippewa County

Inspection Info

Report Number: F7935251155
Inspection Type: Full
Date: 10/16/2025
Time: 10:07:45 AM

Equipment Temperature: Product/Item/Unit: True Upright**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: GE (memory care)**; Temperature Process:** Cold-Holding
Location: Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

CLARA CITY ASSISTED LIVING
Clara City
County/Group: Chippewa County

Inspection Info

Report Number: F7935251155
Inspection Type: Full
Date: 10/16/2025
Time: 10:07:45 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 168 Degrees F.
Comment:
Violation Issued?: No