



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 30, 2026

Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

RE: CCN: 245218

Cycle Start Date: July 31, 2026

Dear Administrator:

On September 4, 2026, we notified you a remedy was imposed. On September 29, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 22, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 31, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 4, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 31, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 22, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

Re: Reinspection Results
Event ID: 28547B-H1

Dear Administrator:

On September 29, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 20, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
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E0000	Initial Comments On (8/17/26-8/20/26), a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			09/22/2026
F0000	INITIAL COMMENTS On 8/17/26-8/20/26, a standard recertification survey (S#5218039) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52183726C (iQIES#: 2960738), H52183727C (iQIES#: 25900662). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)			F0656	Corrective Action: R16 does not smoke anymore. R16's care plan was updated to reflect this change.		09/22/2026

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 reverse for further 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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F0656 SS = D	Continued from page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a comprehensive care			F0656	Continued from page 1 Corrective Action as it applies to other residents: An audit was completed to ensure residents who smoke have an appropriate care plan in place. The Individualized Care Plan policy was reviewed and remains current. Nursing staff will be re-educated regarding the Individualized Care Plan policy. Reoccurrence will be prevented by: Audits will be conducted two times a week for 2 months to ensure residents who smoke have an appropriate care plan in place to address safe smoking practices. Results of the audits will be brought to QAPI for review and further recommendation. Date of Completion: 9/22/2026 The correction will be monitored by: Director of Nursing or designee.		09/22/2026

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F0656 SS = D	Continued from page 2 plan was developed, revised and implemented to address unsafe smoking practices for 1 of 1 residents (R16) reviewed for smoking. R16 was found in the facility parking lot smoking a cigarette within close proximity of an active oxygen source. Findings include. See also F689 R16's quarterly Minimum Data Set (MDS) dated 7/1/26, indicated R16 was cognitively intact, uses oxygen and was dependent on staff for mobility. R16's smoking assessment dated 6/25/26 indicated R16 the interdisciplinary team recommended that the resident cannot smoke independently. R16's smoking assessment dated 8/8/26 indicated R16 failed due unsafe oxygen use. The "comments" section of the assessment indicated, "CNA reported that resident had cigarette lit in his mouth with nasal cannula/oxygen flowing." R16's respiratory care plan entered 7/7/26 indicated R16 has a "smoking history" although it lacked interventions regarding oxygen safety. R16's behavior care plan created 7/24/26 and undated 8/18/26 indicated resident also going out to the parking lot and at times entering staff vehicles to try and get cigarettes or lighters. R16's care plan lacked revisions or safety interventions following the 8/8/26 oxygen-smoking incident. A notation indicating staff should keep vehicles locked was retrospectively entered on 8/18/26. R16's nursing assistant kardex indicated R16 used 2 liters per minute of oxygen via nasal prongs, although lacked resident smoking history, the 8/8/26 smoking with oxygen incident or any further smoking interventions. During interview on 8/18/26 at 2:59 p.m., nursing assistant (NA)-A stated she had worked for the facility for approximately 6 months and was somewhat familiar with R16. NA-A stated she was not certain if R16 smokes and had heard R16 may have been looking and taking cigarettes from people's vehicles. During an interview on 8/18/26 at 3:08 p.m., NA-B stated she had worked at the facility for a year and a half. NA-B stated she heard R16 was caught out in the parking lot about a week prior. During an interview on 8/18/26 at 3:14 p.m., NA-C			F0656			09/22/2026

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F0656 SS = D	Continued from page 3 stated she had worked at the facility for 2 years. NA-C stated R16 was observed about a week ago inside a staff members vehicle. R16 had a lit cigarette while wearing his oxygen. NA-C stated that was the only time she was aware R16 was caught smoking but had previously been seen taking things out of people's vehicles in the parking lot. During a follow up interview on 8/18/26 at 4:04 p.m., NA-C stated prior to the incident on 8/8/26, the nurses informed staff to keep their vehicles locked because R16 was found looking through vehicles, presumably looking for cigarettes. During an interview on 8/18/26 at 4:09 p.m., registered nurse (RN)-A stated he had heard R16 was caught going through vehicles in the parking lot looking for a lighter a couple weekends ago; however, he was not aware of R16 smoking. During an interview on 8/18/26 at 4:40 p.m., with the director of nursing (DON) and nurse manager (NM)-C, the DON stated nurse managers perform smoking assessments to make sure residents can safely handle smoking materials and go across the street to smoke safely. The DON stated she had never performed a smoking assessment. NM-C reviewed R16's 6/25/26 smoking assessment and confirmed it stated R16 passed the assessment however; it also indicated R16 was not safe to smoke independently. NM-C stated becoming aware on 8/10/26 of R16 going through vehicles however; was not aware of any issue prior to that. The DON reviewed the progress note from 8/8 that indicated R16 was seen in a staff member's vehicle in the parking lot looking for a lighter. R16 was removed from the area and educated not to go into staff vehicles. The DON stated the progress note does not indicate R16 was smoking. NM-C reviewed the smoking assessment on 8/8/26 and confirmed all questions were answered "yes" except the question referring to removal of oxygen indicated "no". NM-C stated, "he didn't remove the oxygen apparently." NM-C then stated R16 has been known to wear the oxygen tubing without the oxygen running because R16 feels more comfortable wearing it. When asked who updates the care plans, NM-C stated the MDS nurse usually creates the initial care plan, but all nurses know how to go in and update them. Any incidents are usually entered into the care plan by the nurse managers however the MDS nurse will also occasionally enter them. During an interview on 8/19/26 at 8:28 a.m., LPN-D and NA-G stated they received notification 'a few months ago' to ensure personal vehicles were kept			F0656			09/22/2026

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F0656 SS = D	Continued from page 4 locked because a resident was going through staff vehicles. They were not told why but had heard from other staff a resident was going through vehicles looking for cigarettes. They were not aware of any other incidents. During an interview on 8/19/26 at 9:36 a.m., NM-A stated R16 was previously on the short-term rehab unit prior to transferring to the long-term care unit. NM-A stated when R16 transferred to the long-term care unit, she was not aware R16 smoked or was on a nicotine patch. When she found out R16 was caught smoking in the parking lot with oxygen on, she discussed with R16 weaning off the oxygen and increasing the dose of his nicotine patch. NM-A stated she was not aware of any other time R16 was in the parking lot going through vehicles. NM-A stated a smoking assessment is done based on a resident's cognitive ability, physical limitations, and clinical judgment. Staff do not actually observe resident smoking when performing a smoking assessment. NM-A reviewed R16's care plan and could not find mention of R16 smoking in the parking lot with oxygen on. NM-A stated R16's kardex indicated "staff aware to keep vehicles locked to prevent rummaging by residents" however it was entered on 8/18/26 not when the incident occurred. During a follow-up interview on 8/19/26 at 10:01 a.m., with the DON and NM-C, the DON reviewed R16's care plan and confirmed a notation regarding R16 entering staff vehicles was retrospectively entered on 8/18/26 by NM-C. The care plan also indicated on 7/29/26 R16 was "educated on smoking policy" however neither the DON nor NM-C could recall why. Both confirmed there were no other updates to R16's care plan regarding the incident on 8/8/26. When asked how staff would know R16 was caught going through vehicles in the parking lot and smoking with oxygen on, NM-C stated it would get passed on shift-to-shift report. When asked how long she would expect the incident to be passed on in report, NM-C stated, "a few days." The DON stated incidents are also on the communication page of the electronic health record for staff to review at the beginning of their shift. When asked how long the incident would remain on the communication page, the DON and NM-C were not able to identify the date of the incident on the communication page after taking several minutes to search. Both the DON and NM-C stated they were not aware of any other incident involving R16 in the parking lot. A policy titled "Individualized care Plan" dated 7/25			F0656			09/22/2026

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F0656 SS = D	Continued from page 5 indicated "A comprehensive care plan using comprehensive assessments, will individualize the plan of care to accurately reflect resident's functional capacity and medical, nursing, psychosocial, and activity, and other identified needs. Upon admission, the nursing department begins the care plan and addresses the immediate needs of the residents in the initial care plan. The interdisciplinary team (IDT) team assures all disciplines have shared their information and all problems, services and adaptive equipment are incorporated into the plan. The IDT also assures the resident's care plan is revised if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change because of an incident of abuse. All changes are entered into the appropriate area of the plan. Those interventions flow into the nursing assistant kardex for nursing assistants to provide residents' care. The interdisciplinary care plan is changed promptly in response to any change in the residents' condition. This change is initiated by any professional who recognizes the need to change the plan. The interdisciplinary team also develop individualized care plan interventions with the provider to review refusal and develop new goals and treatment interventions.			F0656			09/22/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision and an environment free from accident hazards for 1 of 1 residents (R16) reviewed for smoking. R16 was found in the facility parking lot smoking a cigarette within close proximity of an active oxygen source. Findings include: R16's quarterly Minimum Data Set dated 7/1/26,			F0689	Corrective Action: R16 does not smoke anymore. Resident is on a cessation plan, which is reflected in the care plan. Corrective Action as it applies to other residents: An audit was conducted to determine residents who have a history of smoking. No residents who are actively smoking. The Oxygen Administration/Storage policy was reviewed and remains current. Tobacco Free/No Smoking policy was reviewed and revised. Ebenezer Smoking Standards were reviewed and remain current. Staff will be re-educated regarding the Oxygen Administration/Storage policy, Tobacco Free/No Smoking policy and Ebenezer Smoking Standards. Reoccurrence will be prevented by: Observation audits two times a week for 2 months to ensure residents that use oxygen, that the oxygen equipment is removed and maintained in a safe and secure manner prior to smoking. Results of the		09/22/2026

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F0689 SS = D	Continued from page 6 indicated R16 was cognitively intact, used oxygen and was dependent on staff for wheelchair mobility. R16 had a history of stroke, respiratory failure, heart failure, and chronic obstructive pulmonary disease (COPD). The MDS also indicated R16 did not use tobacco products. R16's July Medication Administration Record (MAR) indicated R16 received a nicotine transdermal patch 7 mg daily until 8/7/26 and "nursing to trial weaning of oxygen use" and was wearing oxygen 75 of 93 observations. R16's August MAR indicated R16's Nicotine transdermal patch was increased to 14 mg per 24 hours on 8/8/26 and received oxygen 25 of 31 observations. On 8/7/26 R16's oxygen order indicated 2 liters via nasal cannula to achieve oxygen saturation greater than 89% for COPD. R16's smoking assessment dated 6/25/26 indicated R16 was on oxygen and demonstrated the ability to leave the oxygen in the facility before leaving the building and had the ability to manage smoking materials and smoke safely. Question 13 of the smoking assessment indicated R16 passed the smoking assessment. Question 13A indicated the interdisciplinary team recommended the resident cannot smoke independently but may smoke with his/her family or visitors. "Smoking Policy and standards still apply". The smoking assessment also indicated R16 has a smoking care plan. R16's smoking assessment dated 8/8/26 indicated R16 was able to manage smoking materials and demonstrated safe smoking practices. It also indicated R16 did not demonstrate the ability to leave oxygen in facility before leaving the building. Question 13 indicated R16 failed the smoking assessment. Question 13A indicated the interdisciplinary team recommended R16 cannot smoke independently but may smoke with his/her family or visitors. "Smoking policy and standards still apply." The "comments" section of the assessment indicated "CNA reported that resident had cigarette lit in his mouth with nasal cannula/oxygen flowing. Educated resident importance of not having oxygen at the time of smoking a cigarette. R16's respiratory care plan entered 7/7/26 indicated R16 has a "smoking history" although it lacked interventions regarding oxygen safety. R16's behavior care plan created 7/24/26 and updated 8/18/26 indicated resident also going out to the parking lot and at times entering staff vehicles to try and get cigarettes or lighters. R16's care plan lacked revisions or safety interventions following the			F0689	Continued from page 6 audits will be brought to QAPI for review and further recommendation. Date of Completion: 9/22/2026 The correction will be monitored by: Director of Nursing or designee.		09/22/2026

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F0689 SS = D	Continued from page 7 8/8/26 oxygen-smoking incident. A notation indicating staff should keep vehicles locked was retrospectively entered on 8/18/26. R16's nursing assistant kardex indicated R16 used 2 liters per minute of oxygen via nasal prongs, although lacked resident smoking history, the 8/8/26 smoking with oxygen incident or any further smoking interventions. Facility progress notes indicated the following: -On 8/5/26 between 7:30 p.m. and 8:00 p.m., R16 was self-propelling himself down the hallway asking several nursing assistants for cash to purchase a cigarette. -On 8/6/26 the progress notes indicated a new physician order to increase nicotine patch to 14 mg and to attempt to wean the resident from oxygen. -On 8/8/26 at 7:41 p.m., a progress note indicated at 5:30 p.m., R16 left the building through the front door and entered a staff members vehicle in the parking lot in search of a lighter and had 6 cigarettes confiscated. -on 8/10/26 progress notes indicated staff spoke to R16 about him “getting into a vehicles in the parking lot and reports of him smoking.” The note indicated plans to wean off oxygen and the recent increase of his nicotine patch. The progress notes indicated R16 reported smoking at least 1 pack per day prior to admission to the facility. During an observation and interview on 8/18/26 at 12:31 p.m., R16 stated he used to smoke, however is not allowed to smoke at the facility and doesn't smoke with family because "they don't visit". R16 stated he does have a smoking patch on and has not smoked in 3 months. He reported he does not keep cigarettes in his room. A liquid oxygen tank was observed in R16's room. R16 stated he only wears oxygen when he feels short of breath. During an interview on 8/18/26 at 3:08 p.m. NA-B stated she had never seen resident smoke but has heard he does. NA-B stated, "people have caught him outside lighting cigarettes." NA-B stated R16 sits out in front [of the facility] a lot. NA-B stated she heard about a week prior to the interview R16 was caught out in a staff member’s vehicle with a cigarette in his mouth. During an interview on 8/18/26 at 3:14 p.m., NA-C stated she was not sure if R16 had his own supply			F0689			09/22/2026

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F0689 SS = D	Continued from page 8 of cigarettes. NA-C stated R16 has had previous encounters of stealing out of people's vehicles. NA-C stated she and another staff member recently found R16 outside in a staff member's vehicle grabbing a lighter. R16 had a lit cigarette in his mouth and had his oxygen on. The other staff member grabbed the cigarette from R16 and put it out immediately. At that time, one of the nurses came out to get R16. NA-C stated she was not sure where R16 got the cigarettes, however R16 told her they were his. During an interview on 8/18/26 at 3:36 p.m., R16 stated he does not remember going into a staff members vehicle looking for a lighter recently. R16 stated if he chose to smoke, he would have to go "across the street" because he cannot smoke at the facility. R16 stated he does not smoke with oxygen on because oxygen "fuels the fire" and if he did, he would "blow up". During a follow up interview on 8/18/26 at 4:04 p.m. NA-C stated she heard R16 had previously been observed in the same staff members vehicle, "presumably looking for cigarettes" and staff were told to keep vehicles locked. NA-C stated when R16 was alone when he was observed smoking and she was not aware of any other residents who smoked. During an observation and interview on 8/19/26 at 4:09 p.m., registered nurse (RN)-A stated wears oxygen intermittently and uses portable liquid oxygen tank. A portable liquid oxygen tank was observed on the windowsill near the large liquid oxygen tank. RN-A stated he was aware of R16 "rummaging" in vehicles a "couple weekends ago looking for a lighter". To his knowledge that was the only time. During an interview on 8/18/26 at 4:40 p.m., the director of nursing stated smoking assessments are performed by the nurse managers upon a resident's admission. The DON stated the assessments are performed to make sure residents are safe to smoke. The assessment takes into consideration a resident's cognition, oxygen use, and safety crossing the street. The DON stated she has never done a smoking assessment and called in nurse manager (NM)-C. NM-C reviewed R16's smoking assessment from 6/25/26 and confirmed it stated he passed the smoking assessment, but it also indicated he is not safe and could only smoke with family/friends. NM-C stated she was aware R16 was found in the parking lot on 8/8/26, however, was not aware of any situation prior to that. The DON reviewed the progress notes from 8/8 and stated			F0689			09/22/2026

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F0689 SS = D	Continued from page 9 R16 was witnessed to have opened a staff vehicle in the parking lot in search of a lighter. He was removed from the area and educated not to go into other staff vehicles. One pack of cigarettes was removed. The DON stated the progress note does not mention R16 was smoking. NM-C reviewed smoking assessment from 8/8 and stated R16 "didn't remove the oxygen apparently". NM-C then stated R16 has been known to wear oxygen tubing without the oxygen running as a form of comfort. The DON could not say exactly when she was informed R16 was found smoking in the parking lot and was not aware of any other incidence involving R16. During an interview on 8/19/26 at 8:08 a.m., licensed practical nurse (LPN)-B confirmed he was the nurse on duty the day R16 was in the parking lot. LPN-B stated a staff member was in another resident's room, looked out the window, and saw R16 in the parking lot by a vehicle with the door open. LPN-B left the building to retrieve R16, however 2 staff members were already bringing R16 back towards the building. R16 was found with 6-7 cigarettes and stated he was looking for a lighter. R16 sits out in front of the building "all the time" and knows a staff member who smokes parks out there. LPN-B stated he was instructed by the charge nurse to take the cigarettes and place them on the nurse manager's desk. LPN-B stated R16 initially told him he got the cigarettes from a staff member but later stated he found them in a bag in his room. LPN-B had never seen R16 smoking before this incident. LPN-B confirmed R16 was wearing the oxygen nasal cannula and the portable oxygen tank at the time he was found in the parking lot. LPN-B educated R16 about going through people's private property. LPN-B stated that is not the first time R16 was seen in the parking lot but was not aware of any other time R16 was going through vehicles. When asked if R16 wears oxygen continuously, LPN-B stated R16 would occasionally go without oxygen for an hour or so but would request to put it back on due to shortness of breath. LPN-B stated he is not aware of R16 wearing oxygen tubing for comfort and not having the oxygen turned on. During an interview on 8/19/26 at 8:12 a.m., RN-B confirmed she was the charge nurse on duty when R16 was found smoking in the parking lot. She was told R16 was "rummaging" though a staff member's vehicle and was wearing oxygen while holding lit cigarette. RN-B stated she instructed LPN-B to take R16's cigarettes away because R16 was wearing the oxygen nasal cannula and she did not want him to "blow himself up." RN-B then notified the nurse			F0689			09/22/2026

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F0689 SS = D	Continued from page 10 manager on-call about the incident and was instructed to complete a repeat smoking assessment. RN-B stated she did not physically observe R16 smoking when she did the smoking assessment; she simply changed the question referring to leaving the oxygen in the building to "no". She then indicated R16 failed the smoking assessment. On 8/10/26 RN-B spoke to the nurse manager who stated the facility was in the process of increasing R16's nicotine patches and weaning him off oxygen. During a follow up interview on 8/19/26 at 8:57 a.m., RN-B stated she doesn't feel it is the first time R16 has been caught going through vehicles. RN-B was not aware of the circumstances but recalls hearing in report R16 has been going through vehicles looking for a lighter. During an interview on 8/19/26 at 9:36 a.m., nurse manager (NM)-A stated she was notified on 8/10/26 of R16 smoking in the parking lot. NM-A stated R16 had previously been on the rehab unit before transferring to the long-term care unit. She stated she was not aware R16 was a smoker or he was on a nicotine patch prior to this incident. NM-A stated she reviewed the progress note indicating R16 was seen in the parking lot looking for cigarettes. NM-A stated she can see from her office R16 sits outside of the building a lot but has never seen him out in the parking lot. NM-A stated when smoking assessments are performed, staff do not visualize the resident smoking. They do the assessment based on a resident's cognition and physical mobility using clinical judgement. NM-A stated after learning about the incident, she met with the administrator to develop a plan based on R16's orders and diagnoses. NM-A stated she and the administrator spoke to R16 about going through other people's vehicles and the dangers of smoking with oxygen. She was not aware of how R16 got the cigarettes. NM-A stated shortly after the incident she was made aware R16 sometimes wears oxygen tubing without the oxygen on. NM-A reviewed R16's care plan and stated on 8/18/26 R16's care plan was changed to indicate he occasionally wears tubing without oxygen on. NM-A stated she cannot find anything on the care plan specifically about the incident when he was caught smoking. When asked how staff would know of the behavior, NM-A stated incidents are put on the "communication" page in the electronic charting system. NM-A was unable to find the incident on the communication page because it only goes back a week. NM-A reviewed the nursing assistant kardex and stated there was notation stating "staff are aware that they should			F0689			09/22/2026

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F0689 SS = D	Continued from page 11 keep vehicles locked to prevent rummaging through by residents" however the entry was not made until 8/18/26. During a joint interview on 8/19/26 at 10:01 a.m. with the DON and NM-C, they confirmed R16's care plan was not updated regarding the incident until 8/18/26. NM-C stated on R16's care plan indicated R16 was "educated on smoking policy" on 7/29/26 however, does not know why. NM-C confirmed no other updates were made to R16's care plan regarding the incident on 8/8/26. When asked how staff know when incidents occur, NM-C stated they are communicated through shift-to-shift report , “for a few days”. The DON stated changes are also placed on the communication page on the electronic charting system. The DON and NM-C could not locate or navigate back to the date on the communication page. Both the DON and NM-C stated they were not aware of any prior issues with R16 being in the parking lot. The DON stated if a resident is caught in the parking lot going through vehicles or smoking unsafely, she would expect staff to immediately intervene and make sure the resident is safe. Once the resident is safe, she expects staff to let the charge nurse and administration staff know. During an interview on 8/20/26 at 8:48 a.m., NM-B stated she was on call the day R16 was caught smoking in the parking lot. NM-B stated she was told R16 was in the parking lot between the vehicles smoking but was not aware he was wearing oxygen at the time. NM-B stated she instructed the floor nurse to document a comprehensive progress note, do a smoking assessment, and monitor R16 over the weekend to make sure he does not go back out in the parking lot. NM-B stated that is the first time she is aware of an incident of R16 in the parking lot. During an interview on 8/20/26 at 9:44 a.m., the administrator stated he was informed the following Monday that R16 had gotten into a staff member's vehicle and was found smoking. R16 was wearing his oxygen tubing at the time but he did not know if oxygen was turned on. The administrator stated R16 was known to wear oxygen tubing without the oxygen on. The administrator stated he went with NM-A to speak to R16 about the incident and told R16 he cannot go into the parking lot and go through vehicles, even if he feels he is friends with the staff member. The administrator stated R16 has been indecisive about quitting smoking but was agreeable to wean off oxygen and increase his nicotine patch.			F0689			09/22/2026

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F0689 SS = D	Continued from page 12 During an interview on 8/20/26 at 10:00 a.m., the customer service representative (CSR) of the facility's oxygen supply company confirmed the portable oxygen tanks the facility uses contain liquid oxygen. The CSR stated even if the oxygen flow valve is set to 0 there still could be a residual oxygen cloud and potential the valves could leak oxygen. She said there could also still be oxygen present in the tubing even with the valve off. The CSR stated while oxygen itself is not flammable, it acts as an accelerant and can cause a fire if exposed to an open flame. The CSR stated, even with the valve off, there should be no smoking anywhere near oxygen equipment. All smoking should be a minimum of 50 feet away from any oxygen source. A policy titled “Tobacco Free/No smoking” revised 12/25 indicated residents and visitors are not allowed to smoke or use tobacco in facility buildings or property. Residents and visitors will be informed of the tobacco policy through pre-admission and/or admission materials. If a resident or visitor insists on smoking in violation of this policy, the unit manager, house supervisor, or administrator should be notified to address the situation. Residents will be offered cessation support and any cessation treatment plans in accordance with their provider approval and required orders. An undated form titled “Ebenezer Smoking Standards:” indicated the facility is a smoke free campus, and the standards apply to those residents who decide to smoke safely off the campus premises. Residents must abide by the smoking policy which includes refraining from smoking in the building or anywhere on the property, and proper use and storage of flammable materials. Residents and visitors must leave the flammable materials at the nurses’ station after using any of the materials. Residents requiring the use of oxygen must leave oxygen in the building prior to exiting to smoke. Residents must sign out with nurses’ station before leaving building to smoke. Resident's must pass facility smoking assessment to independently smoke. The facility is not responsible for unsafe smoking by residents who are not on the premises when using flammable materials and/or smoking. A policy titled “Oxygen Administration/Storage” dated 12/24 indicated “there is always a danger of fire when oxygen is being used.” “Be sure to explain the hazard of smoking in the presence of oxygen to residents and families. No open flames or smoking in a room where oxygen is being present. Turn oxygen off when not in use.” The oxygen storage			F0689			09/22/2026

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F0689 SS = D	Continued from page 13 section states oxygen equipment should not be stored near a flame or heat source.			F0689			09/22/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On (8/17/26-8/20/26), a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H52183726C (iQIES#: 2960738), H52183727C (iQIES#:			20000			09/22/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 25900662) NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES.	20000		09/22/2026	
20270	Use of Oxygen CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	20270	CORRECTED	09/22/2026	

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20270	Continued from page 2 Based on observation, interview and record review, the facility failed to provide adequate supervision and an environment free from accident hazards for 1 of 1 residents (R16) reviewed for smoking. R16 was found in the facility parking lot smoking a cigarette within close proximity of an active oxygen source. Findings include: R16's quarterly Minimum Data Set dated 7/1/26, indicated R16 was cognitively intact, used oxygen and was dependent on staff for wheelchair mobility. R16 had a history of stroke, respiratory failure, heart failure, and chronic obstructive pulmonary disease (COPD). The MDS also indicated R16 did not use tobacco products. R16's July Medication Administration Record (MAR) indicated R16 received a nicotine transdermal patch 7 mg daily until 8/7/26 and "nursing to trial weaning of oxygen use" and was wearing oxygen 75 of 93 observations. R16's August MAR indicated R16's Nicotine transdermal patch was increased to 14 mg per 24 hours on 8/8/26 and received oxygen 25 of 31 observations. On 8/7/26 R16's oxygen order indicated 2 liters via nasal cannula to achieve oxygen saturation greater than 89% for COPD. R16's smoking assessment dated 6/25/26 indicated R16 was on oxygen and demonstrated the ability to leave the oxygen in the facility before leaving the building and had the ability to manage smoking materials and smoke safely. Question 13 of the smoking assessment indicated R16 passed the smoking assessment. Question 13A indicated the interdisciplinary team recommended the resident cannot smoke independently but may smoke with his/her family or visitors. "Smoking Policy and standards still apply". The smoking assessment also indicated R16 has a smoking care plan. R16's smoking assessment dated 8/8/26 indicated R16 was able to manage smoking materials and demonstrated safe smoking practices. It also indicated R16 did not demonstrate the ability to leave oxygen in facility before leaving the building. Question 13 indicated R16 failed the smoking assessment. Question 13A indicated the interdisciplinary team recommended R16 cannot smoke independently but may smoke with his/her family or visitors. "Smoking policy and standards still apply." The "comments" section of the assessment indicated "CNA reported that resident had cigarette lit in his mouth with nasal cannula/oxygen flowing. Educated resident importance of not having oxygen at the time of		20270			09/22/2026	

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20270	Continued from page 3 smoking a cigarette. R16's respiratory care plan entered 7/7/26 indicated R16 has a "smoking history" although it lacked interventions regarding oxygen safety. R16's behavior care plan created 7/24/26 and updated 8/18/26 indicated resident also going out to the parking lot and at times entering staff vehicles to try and get cigarettes or lighters. R16's care plan lacked revisions or safety interventions following the 8/8/26 oxygen-smoking incident. A notation indicating staff should keep vehicles locked was retrospectively entered on 8/18/26. R16's nursing assistant kardex indicated R16 used 2 liters per minute of oxygen via nasal prongs, although lacked resident smoking history, the 8/8/26 smoking with oxygen incident or any further smoking interventions. Facility progress notes indicated the following: -On 8/5/26 between 7:30 p.m. and 8:00 p.m., R16 was self-propelling himself down the hallway asking several nursing assistants for cash to purchase a cigarette. -On 8/6/26 the progress notes indicated a new physician order to increase nicotine patch to 14 mg and to attempt to wean the resident from oxygen. -On 8/8/26 at 7:41 p.m., a progress note indicated at 5:30 p.m., R16 left the building through the front door and entered a staff members vehicle in the parking lot in search of a lighter and had 6 cigarettes confiscated. -on 8/10/26 progress notes indicated staff spoke to R16 about him "getting into a vehicles in the parking lot and reports of him smoking." The note indicated plans to wean off oxygen and the recent increase of his nicotine patch. The progress notes indicated R16 reported smoking at least 1 pack per day prior to admission to the facility. During an observation and interview on 8/18/26 at 12:31 p.m., R16 stated he used to smoke, however is not allowed to smoke at the facility and doesn't smoke with family because "they don't visit". R16 stated he does have a smoking patch on and has not smoked in 3 months. He reported he does not keep cigarettes in his room. A liquid oxygen tank was observed in R16's room. R16 stated he only wears oxygen when he feels short of breath. During an interview on 8/18/26 at 3:08 p.m. NA-B		20270			09/22/2026	

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20270	Continued from page 4 stated she had never seen resident smoke but has heard he does. NA-B stated, "people have caught him outside lighting cigarettes." NA-B stated R16 sits out in front [of the facility] a lot. NA-B stated she heard about a week prior to the interview R16 was caught out in a staff member's vehicle with a cigarette in his mouth. During an interview on 8/18/26 at 3:14 p.m., NA-C stated she was not sure if R16 had his own supply of cigarettes. NA-C stated R16 has had previous encounters of stealing out of people's vehicles. NA-C stated she and another staff member recently found R16 outside in a staff member's vehicle grabbing a lighter. R16 had a lit cigarette in his mouth and had his oxygen on. The other staff member grabbed the cigarette from R16 and put it out immediately. At that time, one of the nurses came out to get R16. NA-C stated she was not sure where R16 got the cigarettes, however R16 told her they were his. During an interview on 8/18/26 at 3:36 p.m., R16 stated he does not remember going into a staff members vehicle looking for a lighter recently. R16 stated if he chose to smoke, he would have to go "across the street" because he cannot smoke at the facility. R16 stated he does not smoke with oxygen on because oxygen "fuels the fire" and if he did, he would "blow up". During a follow up interview on 8/18/26 at 4:04 p.m. NA-C stated she heard R16 had previously been observed in the same staff members vehicle, "presumably looking for cigarettes" and staff were told to keep vehicles locked. NA-C stated when R16 was alone when he was observed smoking and she was not aware of any other residents who smoked. During an observation and interview on 8/19/26 at 4:09 p.m., registered nurse (RN)-A stated wears oxygen intermittently and uses portable liquid oxygen tank. A portable liquid oxygen tank was observed on the windowsill near the large liquid oxygen tank. RN-A stated he was aware of R16 "rummaging" in vehicles a "couple weekends ago looking for a lighter". To his knowledge that was the only time. During an interview on 8/18/26 at 4:40 p.m., the director of nursing stated smoking assessments are performed by the nurse managers upon a resident's admission. The DON stated the assessments are performed to make sure residents are safe to smoke. The assessment takes into consideration a resident's cognition, oxygen use, and safety			20270			09/22/2026

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NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
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20270	Continued from page 5 crossing the street. The DON stated she has never done a smoking assessment and called in nurse manager (NM)-C. NM-C reviewed R16's smoking assessment from 6/25/26 and confirmed it stated he passed the smoking assessment, but it also indicated he is not safe and could only smoke with family/friends. NM-C stated she was aware R16 was found in the parking lot on 8/8/26, however, was not aware of any situation prior to that. The DON reviewed the progress notes from 8/8 and stated R16 was witnessed to have opened a staff vehicle in the parking lot in search of a lighter. He was removed from the area and educated not to go into other staff vehicles. One pack of cigarettes was removed. The DON stated the progress note does not mention R16 was smoking. NM-C reviewed smoking assessment from 8/8 and stated R16 "didn't remove the oxygen apparently". NM-C then stated R16 has been known to wear oxygen tubing without the oxygen running as a form of comfort. The DON could not say exactly when she was informed R16 was found smoking in the parking lot and was not aware of any other incidence involving R16. During an interview on 8/19/26 at 8:08 a.m., licensed practical nurse (LPN)-B confirmed he was the nurse on duty the day R16 was in the parking lot. LPN-B stated a staff member was in another resident's room, looked out the window, and saw R16 in the parking lot by a vehicle with the door open. LPN-B left the building to retrieve R16, however 2 staff members were already bringing R16 back towards the building. R16 was found with 6-7 cigarettes and stated he was looking for a lighter. R16 sits out in front of the building "all the time" and knows a staff member who smokes parks out there. LPN-B stated he was instructed by the charge nurse to take the cigarettes and place them on the nurse manager's desk. LPN-B stated R16 initially told him he got the cigarettes from a staff member but later stated he found them in a bag in his room. LPN-B had never seen R16 smoking before this incident. LPN-B confirmed R16 was wearing the oxygen nasal cannula and the portable oxygen tank at the time he was found in the parking lot. LPN-B educated R16 about going through people's private property. LPN-B stated that is not the first time R16 was seen in the parking lot but was not aware of any other time R16 was going through vehicles. When asked if R16 wears oxygen continuously, LPN-B stated R16 would occasionally go without oxygen for an hour or so but would request to put it back on due to shortness of breath. LPN-B stated he is not aware of R16 wearing oxygen tubing for comfort and not having the oxygen turned on.			20270			09/22/2026

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20270	Continued from page 6 During an interview on 8/19/26 at 8:12 a.m., RN-B confirmed she was the charge nurse on duty when R16 was found smoking in the parking lot. She was told R16 was "rummaging" though a staff member's vehicle and was wearing oxygen while holding lit cigarette. RN-B stated she instructed LPN-B to take R16's cigarettes away because R16 was wearing the oxygen nasal cannula and she did not want him to "blow himself up." RN-B then notified the nurse manager on-call about the incident and was instructed to complete a repeat smoking assessment. RN-B stated she did not physically observe R16 smoking when she did the smoking assessment; she simply changed the question referring to leaving the oxygen in the building to "no". She then indicated R16 failed the smoking assessment. On 8/10/26 RN-B spoke to the nurse manager who stated the facility was in the process of increasing R16's nicotine patches and weaning him off oxygen. During a follow up interview on 8/19/26 at 8:57 a.m., RN-B stated she doesn't feel it is the first time R16 has been caught going through vehicles. RN-B was not aware of the circumstances but recalls hearing in report R16 has been going through vehicles looking for a lighter. During an interview on 8/19/26 at 9:36 a.m., nurse manager (NM)-A stated she was notified on 8/10/26 of R16 smoking in the parking lot. NM-A stated R16 had previously been on the rehab unit before transferring to the long-term care unit. She stated she was not aware R16 was a smoker or he was on a nicotine patch prior to this incident. NM-A stated she reviewed the progress note indicating R16 was seen in the parking lot looking for cigarettes. NM-A stated she can see from her office R16 sits outside of the building a lot but has never seen him out in the parking lot. NM-A stated when smoking assessments are performed, staff do not visualize the resident smoking. They do the assessment based on a resident's cognition and physical mobility using clinical judgement. NM-A stated after learning about the incident, she met with the administrator to develop a plan based on R16's orders and diagnoses. NM-A stated she and the administrator spoke to R16 about going through other people's vehicles and the dangers of smoking with oxygen. She was not aware of how R16 got the cigarettes. NM-A stated shortly after the incident she was made aware R16 sometimes wears oxygen tubing without the oxygen on. NM-A reviewed R16's care plan and stated on 8/18/26 R16's care plan was changed to indicate he occasionally wears		20270			09/22/2026	

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20270	Continued from page 7 tubing without oxygen on. NM-A stated she cannot find anything on the care plan specifically about the incident when he was caught smoking. When asked how staff would know of the behavior, NM-A stated incidents are put on the "communication" page in the electronic charting system. NM-A was unable to find the incident on the communication page because it only goes back a week. NM-A reviewed the nursing assistant kardex and stated there was notation stating "staff are aware that they should keep vehicles locked to prevent rummaging through by residents" however the entry was not made until 8/18/26. During a joint interview on 8/19/26 at 10:01 a.m. with the DON and NM-C, they confirmed R16's care plan was not updated regarding the incident until 8/18/26. NM-C stated on R16's care plan indicated R16 was "educated on smoking policy" on 7/29/26 however, does not know why. NM-C confirmed no other updates were made to R16's care plan regarding the incident on 8/8/26. When asked how staff know when incidents occur, NM-C stated they are communicated through shift-to-shift report , “for a few days”. The DON stated changes are also placed on the communication page on the electronic charting system. The DON and NM-C could not locate or navigate back to the date on the communication page. Both the DON and NM-C stated they were not aware of any prior issues with R16 being in the parking lot. The DON stated if a resident is caught in the parking lot going through vehicles or smoking unsafely, she would expect staff to immediately intervene and make sure the resident is safe. Once the resident is safe, she expects staff to let the charge nurse and administration staff know. During an interview on 8/20/26 at 8:48 a.m., NM-B stated she was on call the day R16 was caught smoking in the parking lot. NM-B stated she was told R16 was in the parking lot between the vehicles smoking but was not aware he was wearing oxygen at the time. NM-B stated she instructed the floor nurse to document a comprehensive progress note, do a smoking assessment, and monitor R16 over the weekend to make sure he does not go back out in the parking lot. NM-B stated that is the first time she is aware of an incident of R16 in the parking lot. During an interview on 8/20/26 at 9:44 a.m., the administrator stated he was informed the following Monday that R16 had gotten into a staff member's vehicle and was found smoking. R16 was wearing his oxygen tubing at the time but he did not know if oxygen was turned on. The administrator stated R16			20270			09/22/2026

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20270	Continued from page 8 was known to wear oxygen tubing without the oxygen on. The administrator stated he went with NM-A to speak to R16 about the incident and told R16 he cannot go into the parking lot and go through vehicles, even if he feels he is friends with the staff member. The administrator stated R16 has been indecisive about quitting smoking but was agreeable to wean off oxygen and increase his nicotine patch. During an interview on 8/20/26 at 10:00 a.m., the customer service representative (CSR) of the facility's oxygen supply company confirmed the portable oxygen tanks the facility uses contain liquid oxygen. The CSR stated even if the oxygen flow valve is set to 0 there still could be a residual oxygen cloud and potential the valves could leak oxygen. She said there could also still be oxygen present in the tubing even with the valve off. The CSR stated while oxygen itself is not flammable, it acts as an accelerant and can cause a fire if exposed to an open flame. The CSR stated, even with the valve off, there should be no smoking anywhere near oxygen equipment. All smoking should be a minimum of 50 feet away from any oxygen source. A policy titled “Tobacco Free/No smoking” revised 12/25 indicated residents and visitors are not allowed to smoke or use tobacco in facility buildings or property. Residents and visitors will be informed of the tobacco policy through pre-admission and/or admission materials. If a resident or visitor insists on smoking in violation of this policy, the unit manager, house supervisor, or administrator should be notified to address the situation. Residents will be offered cessation support and any cessation treatment plans in accordance with their provider approval and required orders. An undated form titled “Ebenezer Smoking Standards:” indicated the facility is a smoke free campus, and the standards apply to those residents who decide to smoke safely off the campus premises. Residents must abide by the smoking policy which includes refraining from smoking in the building or anywhere on the property, and proper use and storage of flammable materials. Residents and visitors must leave the flammable materials at the nurses’ station after using any of the materials. Residents requiring the use of oxygen must leave oxygen in the building prior to exiting to smoke. Residents must sign out with nurses’ station before leaving building to smoke. Resident’s must pass facility smoking assessment to independently smoke. The facility is not responsible for unsafe smoking by			20270			09/22/2026

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20270	Continued from page 9 residents who are not on the premises when using flammable materials and/or smoking. A policy titled "Oxygen Administration/Storage" dated 12/24 indicated "there is always a danger of fire when oxygen is being used." "Be sure to explain the hazard of smoking in the presence of oxygen to residents and families. No open flames or smoking in a room where oxygen is being present. Turn oxygen off when not in use." The oxygen storage section states oxygen equipment should not be stored near a flame or heat source. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' oxygen equipment is maintained in a safe and secure manner. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those findings to QAPI until compliance is achieved. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20270			09/22/2026	
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a comprehensive care plan was developed, revised and implemented to address unsafe smoking practices for 1 of 1 residents (R16) reviewed for smoking. R16 was found in the facility parking lot smoking a cigarette within close proximity of an active oxygen source.		20555	CORRECTED		09/22/2026	

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20555	Continued from page 10 Findings include. See also F689 R16's quarterly Minimum Data Set (MDS) dated 7/1/26, indicated R16 was cognitively intact, uses oxygen and was dependent on staff for mobility. R16's smoking assessment dated 6/25/26 indicated R16 the interdisciplinary team recommended that the resident cannot smoke independently. R16's smoking assessment dated 8/8/26 indicated R16 failed due unsafe oxygen use. The "comments" section of the assessment indicated, "CNA reported that resident had cigarette lit in his mouth with nasal cannula/oxygen flowing." R16's respiratory care plan entered 7/7/26 indicated R16 has a "smoking history" although it lacked interventions regarding oxygen safety. R16's behavior care plan created 7/24/26 and undated 8/18/26 indicated resident also going out to the parking lot and at times entering staff vehicles to try and get cigarettes or lighters. R16's care plan lacked revisions or safety interventions following the 8/8/26 oxygen-smoking incident. A notation indicating staff should keep vehicles locked was retrospectively entered on 8/18/26. R16's nursing assistant kardex indicated R16 used 2 liters per minute of oxygen via nasal prongs, although lacked resident smoking history, the 8/8/26 smoking with oxygen incident or any further smoking interventions. During interview on 8/18/26 at 2:59 p.m., nursing assistant (NA)-A stated she had worked for the facility for approximately 6 months and was somewhat familiar with R16. NA-A stated she was not certain if R16 smokes and had heard R16 may have been looking and taking cigarettes from people's vehicles. During an interview on 8/18/26 at 3:08 p.m., NA-B stated she had worked at the facility for a year and a half. NA-B stated she heard R16 was caught out in the parking lot about a week prior. During an interview on 8/18/26 at 3:14 p.m., NA-C stated she had worked at the facility for 2 years. NA-C stated R16 was observed about a week ago inside a staff members vehicle. R16 had a lit cigarette while wearing his oxygen. NA-C stated that was the only time she was aware R16 was caught smoking but had previously been seen taking things			20555			09/22/2026

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20555	Continued from page 11 out of people's vehicles in the parking lot. During a follow up interview on 8/18/26 at 4:04 p.m., NA-C stated prior to the incident on 8/8/26, the nurses informed staff to keep their vehicles locked because R16 was found looking through vehicles, presumably looking for cigarettes. During an interview on 8/18/26 at 4:09 p.m., registered nurse (RN)-A stated he had heard R16 was caught going through vehicles in the parking lot looking for a lighter a couple weekends ago; however, he was not aware of R16 smoking. During an interview on 8/18/26 at 4:40 p.m., with the director of nursing (DON) and nurse manager (NM)-C, the DON stated nurse managers perform smoking assessments to make sure residents can safely handle smoking materials and go across the street to smoke safely. The DON stated she had never performed a smoking assessment. NM-C reviewed R16's 6/25/26 smoking assessment and confirmed it stated R16 passed the assessment however; it also indicated R16 was not safe to smoke independently. NM-C stated becoming aware on 8/10/26 of R16 going through vehicles however; was not aware of any issue prior to that. The DON reviewed the progress note from 8/8 that indicated R16 was seen in a staff member's vehicle in the parking lot looking for a lighter. R16 was removed from the area and educated not to go into staff vehicles. The DON stated the progress note does not indicate R16 was smoking. NM-C reviewed the smoking assessment on 8/8/26 and confirmed all questions were answered "yes" except the question referring to removal of oxygen indicated "no". NM-C stated, "he didn't remove the oxygen apparently." NM-C then stated R16 has been known to wear the oxygen tubing without the oxygen running because R16 feels more comfortable wearing it. When asked who updates the care plans, NM-C stated the MDS nurse usually creates the initial care plan, but all nurses know how to go in and update them. Any incidents are usually entered into the care plan by the nurse managers however the MDS nurse will also occasionally enter them. During an interview on 8/19/26 at 8:28 a.m., LPN-D and NA-G stated they received notification 'a few months ago' to ensure personal vehicles were kept locked because a resident was going through staff vehicles. They were not told why but had heard from other staff a resident was going through vehicles looking for cigarettes. They were not aware of any other incidents.			20555			09/22/2026

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20555	Continued from page 12 During an interview on 8/19/26 at 9:36 a.m., NM-A stated R16 was previously on the short-term rehab unit prior to transferring to the long-term care unit. NM-A stated when R16 transferred to the long-term care unit, she was not aware R16 smoked or was on a nicotine patch. When she found out R16 was caught smoking in the parking lot with oxygen on, she discussed with R16 weaning off the oxygen and increasing the dose of his nicotine patch. NM-A stated she was not aware of any other time R16 was in the parking lot going through vehicles. NM-A stated a smoking assessment is done based on a resident's cognitive ability, physical limitations, and clinical judgment. Staff do not actually observe resident smoking when performing a smoking assessment. NM-A reviewed R16's care plan and could not find mention of R16 smoking in the parking lot with oxygen on. NM-A stated R16's kardex indicated "staff aware to keep vehicles locked to prevent rummaging by residents" however it was entered on 8/18/26 not when the incident occurred. During a follow-up interview on 8/19/26 at 10:01 a.m., with the DON and NM-C, the DON reviewed R16's care plan and confirmed a notation regarding R16 entering staff vehicles was retrospectively entered on 8/18/26 by NM-C. The care plan also indicated on 7/29/26 R16 was "educated on smoking policy" however neither the DON nor NM-C could recall why. Both confirmed there were no other updates to R16's care plan regarding the incident on 8/8/26. When asked how staff would know R16 was caught going through vehicles in the parking lot and smoking with oxygen on, NM-C stated it would get passed on shift-to-shift report. When asked how long she would expect the incident to be passed on in report, NM-C stated, "a few days." The DON stated incidents are also on the communication page of the electronic health record for staff to review at the beginning of their shift. When asked how long the incident would remain on the communication page, the DON and NM-C were not able to identify the date of the incident on the communication page after taking several minutes to search. Both the DON and NM-C stated they were not aware of any other incident involving R16 in the parking lot. A policy titled "Individualized care Plan" dated 7/25 indicated "A comprehensive care plan using comprehensive assessments, will individualize the plan of care to accurately reflect resident's functional capacity and medical, nursing, psychosocial, and activity, and other identified needs. Upon admission, the nursing department			20555			09/22/2026

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20555	Continued from page 13 begins the care plan and addresses the immediate needs of the residents in the initial care plan. The interdisciplinary team (IDT) team assures all disciplines have shared their information and all problems, services and adaptive equipment are incorporated into the plan. The IDT also assures the resident's care plan is revised if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change because of an incident of abuse. All changes are entered into the appropriate area of the plan. Those interventions flow into the nursing assistant kardex for nursing assistants to provide residents' care. The interdisciplinary care plan is changed promptly in response to any change in the residents' condition. This change is initiated by any professional who recognizes the need to change the plan. The interdisciplinary team also develop individualized care plan interventions with the provider to review refusal and develop new goals and treatment interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans are used and followed in order to meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are used and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20555			09/22/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 4, 2026

Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

RE: CCN: 245218

Cycle Start Date: July 31, 2026

Dear Administrator:

On August 19, 2026, we informed you that we may impose enforcement remedies.

On August 20, 2026, the Minnesota Departments of Health and Public Safety completed a recertification survey, and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected is/are as follows:

F684, F842, and F775

In addition, at the time of this survey/revisit, we identified the following deficiencies:

F656 (20555), F689 (20270), K712, and K761

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 31, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 31, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 31, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 31, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, MAYO CLINIC HEALTH SYSTEM - LAKE CITY will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 31, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by

the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 31, 2027 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 4, 2026

Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

Re: State Nursing Home Licensing Orders

Event ID: 28547B-H1

Dear Administrator:

The above facility survey was completed on August 20, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion, and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors' findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/18/2026	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
(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) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/18/2026. At the time of this survey, MAYO CLINIC HEALTH SYSTEM - LAKE CITY was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			09/04/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/18/2026	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. MAYO CLINIC HEALTH SYSTEM - LAKE CITY is a one-story building having no basement. The building was constructed at 2 different times. The original building was built in 1977 and was determined to be of Type I (332) construction. In January 2003, the chapel addition was built and was determined to be of Type I (332) construction. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. A 2-hour fire separation exists between the nursing home and the clinic, and the hospital. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for			K0000			09/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/18/2026	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
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K0000 Bldg. 01	Continued from page 2 automatic fire department notification.			K0000			09/04/2026
K0761 SS = F Bldg. 01	The facility has a capacity of 90 beds and had a census of 64 at the time of the survey.			K0761	Exit Door (G) was repaired to ensure it is functioning appropriately.		09/22/2026
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:						
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors			K0761	An audit of exit doors was conducted to ensure all other doors are functioning appropriately. No other doors were identified.		
	CFR(s): NFPA 101				Administrator or designee will re-educate maintenance staff on the requirement that exit doors need to open with less than 15 pounds of force.		
	Maintenance, Inspection & Testing - Doors				Audits will be conducted once a week for two months to ensure exit doors are functioning properly. Results of the audits will be brought to QAPI for review and further recommendation.		
	Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.				Date of Completion: 9/22/2026		
	Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.				The correction will be monitored by: Administrator or designee.		
	Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.						
	Written records of inspection and testing are maintained and are available for review.						
	19.7.6, 8.3.3.1 (LSC)						
	5.2, 5.2.3 (2010 NFPA 80)						
	This STANDARD is NOT MET as evidenced by:						
Based observation, a review of available documentation and staff interview the facility failed to implement door testing documentation per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.7.1(3). This deficient finding could have a widespread impact on the residents within the facility.							
Findings include:							
On 08/18/2026 at 11:30 AM, it was revealed by observation that exit door (G) required greater than 15 lb-of-force to actuate the opening of the door upon test.							
An interview with the Maintenance Director verified this deficient finding at the time of discovery.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/18/2026	
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K0712 SS = C Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/18/2026 between 10:00 AM and 12:30 PM, it was revealed by review of available documentation that fire drill records exhibited lack of randomness and exhibited patterning. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0712	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. Administrator will review policies and procedures for scheduling fire drills. Fire drills will be held under various conditions and times to ensure staff are familiar with procedures. A new schedule has been created to ensure this standard is met. Administrator or designee will re-educate maintenance staff on the requirement to hold fire drills at expected and unexpected times under varying conditions, at least quarterly each shift. Education will be completed by 9/22/2026. Audits will be conducted twice a month for three months and randomly thereafter for three months to ensure fire drills are conducted at varied times. Results of the audits will be brought to QAPI for review and further recommendation. Date of Completion: 9/22/2026 The correction will be monitored by: Administrator or designee.		09/22/2026