DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 4R4C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00359

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245274**
2.STATE VENDOR OR MEDICAID NO.
(L2) **259845104**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAYO CLINIC HEALTH SYSTEM - FAIRMONT**
(L4) **800 MEDICAL CENTER DRIVE, PO BOX 800**
(L5) **FAIRMONT, MN** (L6) **56031**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/22/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
X Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 1/7/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/7/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245274

January 7, 2016

Mr. Michael Corchran, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive, PO Box 800
Fairmont, MN 56031

Dear Mr. Corchran:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 27, 2015 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

Electronically delivered
January 7, 2016

Mr. Michael Corchran, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive, PO Box 800
Fairmont, MN 56031

RE: Project Number S5274025

Dear Mr. Corchran:

On November 16, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 29, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 3, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 27, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 29, 2015, effective December 22, 2015 and therefore remedies outlined in our letter to you dated November 16, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245274	A. Building B. Wing	12/22/2015

Name of Facility	Street Address, City, State, Zip Code
MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **11/19/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/22/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/22/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/22/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/22/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/22/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/22/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/22/2015**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **12/22/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	01/07/2016	22113	12/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/29/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245274	A. Building B. Wing **01 - MAIN BUILDING 01**	12/3/2015

Name of Facility	Street Address, City, State, Zip Code
MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/30/2015**	ID Prefix	Correction Completed **10/28/2015**	ID Prefix	Correction Completed **10/30/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0050		LSC K0072		LSC K0154	
ID Prefix	Correction Completed **10/30/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0155		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/kfd	1/7/2016	35482	12/3/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/28/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 4R4C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00359

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(L2) **259845104**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAYO CLINIC HEALTH SYSTEM - FAIRMONT**
(L4) **800 MEDICAL CENTER DRIVE, PO BOX 800**
(L5) **FAIRMONT, MN** (L6) **56031**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/29/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 12/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/14/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

November 16, 2015

Mr. Michael Corchran, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive, PO Box 800
Fairmont, MN 56031

RE: Project Number S5274025

Dear Mr. Corchran:

On October 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 8, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by January 29, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 April 29, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

(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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to make the most recent survey results available and failed to post them in a place readily accessible for residents to review. This has the potential to affect all residents, visitors and staff.	F 167	On 10-27-15 the 2015 survey results were placed in the white binder and placed on a shelf that is easily accessible to residents in wheel chairs. DON or designee will monitor the placement of the binder on a weekly basis. DON or designee will verify the	11/27/15

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

Electronically Signed | 11/27/2015

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MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

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F 167	Continued From page 1 Findings include: During the initial tour on 10/26/15, at 10:35 a.m. a notice was posted on a bulletin board located across from the dining room. The notice directed residents and visitors to the survey results located in a 3-ring binder on the top shelf of a bookcase in the activities department. The survey results were located on the top shelf and not accessible to wheelchair bound residents. During review of the available survey results, it was noted they were not current but were dated 10/28/11. When interviewed on 10/26/15, at 11:10 a.m. the director of nursing (DON) verified the survey results were not accessible to wheelchair bound residents nor were the current survey results made available in the 3-ring binder.	F 167	most recent survey is in the binder and accessible to residents prior to each QA meeting for the next year.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		11/27/15

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F 280	Continued From page 2 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise the plan of care to include additional staff assistance for 1 of 2 residents (R29) reviewed for accidents. Findings include: R29's Diagnosis Report located in the medical record indicated R29 had diagnoses including: hereditary and idiopathic neuropathy, malaise, anemia, chronic pain, macular degeneration, restless leg syndrome and anxiety disorder. R29's plan of care dated 8/11/15, identified R29 as having a history of falls including sustaining a left femur fracture with a fall on 12/5/13. Interventions included: limited to extensive assistance of 1 for toileting and extensive assistance of 1 for transfers. Record review indicated R29 had a fall on 10/5/15, at 4:15 p.m. The Fall's Event Report identified the nature of the incident as a fall during one assist while transferring from the toilet to the wheelchair. The report indicated the root cause of the fall was R29's legs and knees giving out and staff unable to keep R29 from falling. The report indicated the initial intervention to prevent future falls included having another staff member assist with transferring off the toilet to the wheelchair.	F 280	Education was given to Nurses that care plans need to be updated as care, conditions change for residents. R29's Care Plan was updated to reflect transfers of one assist. DON or designee will continue to do weekly Care plan audits for 6 months then monthly as needed to continue. DON or designee will do care plan audits once a week for a month, once every two weeks for two months and once a month for three months. The results will be reported to the QA committee.	

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F 280	Continued From page 3 R29's plan of care lacked revision indicating R29 required 2 staff to assist with toileting following the fall dated 10/5/15, while transferring from the toilet to the wheelchair. When interviewed on 10/28/15, at 12:45 p.m. nursing assistant (NA)-E stated R29 requires one assist for toileting. NA-E also stated the NA's get their information regarding any changes in resident cares from the communication book, which is passed on during shift reports. When interviewed on 10/28/15, at 1:21 p.m. registered nurse (RN)-B stated interventions are implemented immediately the day a fall occurs. RN-B stated she wasn't aware of the initial intervention indicating that two staff transfer R29 during toileting, post-fall dated 10/5/15. RN-B confirmed the care plan hadn't been updated/revised and therefore the NA's wouldn't be aware of the change. During an interview on 10/28/15, at 1:40 p.m. the director of nursing (DON) confirmed she wasn't aware of the intervention that was to have been added to the care plan and also confirmed there had been no changes to the care plan following the fall on 10/5/15. The DON also confirmed no incident report could be found following the fall on 10/20/15. During an interview on 10/29/15, at 10:19 a.m. NA-F stated R29 requires one person to assist with toileting due to poor balance. NA-F confirmed she wasn't aware of any changes in R29's care plan.	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		11/19/15

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F 309 SS=D	Continued From page 4 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper positioning for 3 of 4 residents (R8, R12, R35) reviewed who utilized wheelchairs. Findings include: The quarterly Minimum Data Set dated 8/5/15, indicated R8 had moderate cognitive impairment and required extensive assistance with all activities of daily living (ADL) and required supervision and cueing for eating. The care plan dated 6/2/15, indicated R8 was to use a tray table to reach her food better. R8 propelled self in wheelchair and the care plan did not address any further wheelchair positioning. When observed on 10/26/15, at 12:05 p.m. R8 was seated in a wheelchair and the back of her wheelchair was positioned to be leaning backwards and her legs were on leg rests extended forward. The legs and footrests were padded. R8 was unable to reach her plate of food located on the table in front of her. R8 fully extended her arms, attempting to reach the food	F 309	R8 □ COTA discussed this resident during the inservice held on 11-19-15. Care Plan was updated. R12□s foot pedals are being used on wheel chair and care plan used updated to reflect this. R35 □ foot pedals are being used on wheel chair and care plan has been updated.Education was given by COTA on 11-19-15 to all nursing staff regarding proper positioning for residents in bed and in wheel chair for comfort and ability to feed self. OT will screen all residents on a quarterly basis for proper positioning. DON or designee will be responsible for monitoring positioning of residents weekly. DON or designee will monitor residents care planned for positioning once a week for a month, once every two weeks for two months and once a month for three months. The results will be reported to the QA committee.	

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F 309	Continued From page 5	F 309		

on her plate. R8 continued trying to reach her food for several minutes when nursing assistant (NA)-B walked by and placed the food in closer proximity. At 12:27 p.m. it was noted that R8's foot was falling/sliding off the foot pedal. R8 struggled to get it back on the rest.

The following day, on 10/27/15, at 11:59 a.m. R8 was transported to the dining room for the noon meal. R8 was positioned on the left side of her buttocks and thus facing away from the table. R8's feet were on the foot pedal extended perpendicular to the table. R8 was offered a sip of water by NA-A and then NA-A walked away from the table. R8 continued to try to reach her food many times but was unable. R8 finally put her arm in the dish of food. No staff offered R8 a tray table so that her food could be reached. At 12:04 p.m. NA-A and activity staff (AS)-A pulled R8 up in the wheelchair with the use of the Hoyer canvas located underneath the resident. When staff pulled R8 up in the chair, she remained facing in the direction away from the table. R8's foot slipped off the foot rest again. On 10/27/15, at 12:16 p.m. RN-A and NA-D transported R8 from the dining room to her room with her foot dangling off the foot pedals.

When interviewed on 10/28/15, t 6:16 p.m. the director of nursing (DON) indicated that residents should be positioned appropriately for meals.

The quarterly Minimum Data Set dated 9/9/15, indicated R12 was cognitively impaired and required extensive assistance with all activities of daily living (ADL). R12 had no behaviors.

The care plan dated 8/31/15 indicated encourage R12 "use of a w/c [wheelchair] for locomotion"

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F 309	Continued From page 6 "[R12] has Multiple Sclerosis with generalized weakness worse in her lower extremities" A medical doctor report dated 9/13/15, indicated "...Does have chronic medial conditions of multiple sclerosis, neurogenic bladder, indwelling catheter and depression. .... Is wheelchair bound with significant contractures in her joints." On 10/27/15, at 12:05 p.m. R12 was sitting in the dining room in her wheelchair. There was no leg supports and her legs were hanging down with her toes slightly rubbing the floor. There were no foot pedals on the wheelchair. On 10/28/15, at 7:00 a.m. R12 was sitting in her day room, in her wheelchair. Her foot pedals are not on the wheelchair and both feet were hanging downward with her toes barely touching the floor. There were no foot pedals on her wheelchair. On 10/28/15, at 7:22 a.m. R12 remains seated in the wheelchair, located in the day room, her legs hanging downward. R12's toes barely touch the floor and no leg supports are attached to the wheelchair. On 10/28/15, at 8:05 a.m. staff transported R12 into the dining room, with legs hanging downward and toes intermittently touching the floor while transported. There were no wheelchair leg supports located on the wheelchair. R12's positioning status remained the same during a subsequent observation on 10/28/2015, at 8:58 a.m. On 10/28/15, at 11:54 a.m. R12 is seated in the wheelchair in the day room playing games; feet dangling with no leg supports and no foot pedals attached to the wheelchair. Her toes were	F 309		

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remained bent downward touching the floor.

When interviewed on 10/28/15, at 7:03 a.m. trained medication assistant (TMA)-B stated she didn't know R12's foot pedals were supposed to be utilized with the wheelchair.

On 10/28/15, at 7:07 a.m. TMA-A stated R12 is suppose to have the foot pedal on her wheelchair. She said she didn't know why they were not attached to the wheelchair.

On 10/28/15, at 1:16 p.m. nursing assistant (NA)-E stated R12 is suppose to have her wheelchair leg supports on the wheelchair. She also stated she didn't know why they were not on the chair for the last couple days.

On 10/29/15, at 9:14 a.m. the DON stated R12 should have the foot pedals attached to wheelchair and was unaware of her toes dragging across the floor when the staff transported her in the wheelchair.

The quarterly Minimum Data Set (MDS) dated 9/6/15, indicated R35 had moderate cognitive impairment and required extensive assistance with all activities of daily living (ADL). R35 had no behaviors.

The care plan dated 9/28/15, indicated R35 "at risk for falls r/t [related to] balance issues during transfers, hx [history] of falls, use of antidepressants, weakness." The care plan did not address wheelchair positioning.

On 10/27/15, at 12:33 p.m. R35 requested to be transported to her room. R35 was transported with her feet hanging down to the floor with no

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F 309	Continued From page 8 foot rests attached to the wheelchair. Her toes bounced off the floor as the staff pushed her wheelchair to her room. On 10/27/15, at 5:53 p.m. R35 was sitting in her wheelchair at the dining table. R35's did not have leg supports attached to the wheelchair and her feet were dangling and toes barely touching the floor. It was noted on 10/28/15, at 8:59 a.m. R35 was sitting by the dining room table in the wheelchair with no foot pedals. R35's feet were dangling down with her toes pointed toward the floor. On 10/27/15, from 12:05 p.m. until 5:53 p.m. R35 was sitting in the wheelchair with her feet hanging down, toes barely touching the floor and no leg supports on the wheelchair. When interviewed on 10/28/15, at 12:51 p.m. nursing assistant (NA)-E said R35 is suppose to have her foot pedals on her wheelchair. She said there are foot pedals in her room. On 10/29/15, at 9:14 a.m. the director of nurses (DON) stated R35's foot pedals should be on the wheelchair and she wasn't aware her toes were dragging across the floor when the staff pushed her wheelchair. A positioning facility policy was requested but not received.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311		11/19/15

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F 311	Continued From page 9 specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary services to maintain functional eating skills for 1 of 1 (R8) resident reviewed who required supervision and cueing when dining. Findings include: The quarterly Minimum Data Set (MDS) dated 8/5/15, indicated R8 had moderate cognitive impairment and required supervision and cueing when eating. R8 had no behaviors listed. The care plan dated 6/2/15, indicated: encourage R8 to eat more of meals, offer substitutions if resident does not eat and use a tray table so R8 can reach her food. When observed on 10/26/15, at 12:05 p.m. R8 was seated in a wheelchair with the back of the wheelchair positioned/leaning backwards. R8's legs were positioned forward on the extended, padded leg rests. R8 was unable to reach her plate of food located on the table in front of her. R8 fully extended her arms, attempting to reach the food on her plate. R8 continued trying to reach her food for several minutes when nursing assistant (NA)-B walked by and placed the food in closer proximity. NA-B gave R8 one bite of food at 12:21 p.m. while she remained standing next to R8, and then walked away. R8, who now had a fork, could not reach her food so stabbed at the food many times. Finally, when R8 pierced a whole piece of bread, it fell off the fork but a	F 311	R8 □ COTA discussed this resident during the inservice held on 11-19-15. Care Plan was updated. Education was given to nursing staff ob 11-19-15 by COTA regarding positioning of residents for eating. Staff were instructed to monitor all residents while they are eating and assist as needed. DON or designee will be responsible to monitor resident at meals on a weekly basis. DON or designee will monitor residents care planned to need assistance at meals once a week for a month, once every two weeks for two months and once a month for three months. The results will be reported to the QA committee.	

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small piece remained on the fork, which she consumed.

At 12:22 p.m. activity staff (AS)-A brought a glass of milk with a straw and left it for R8. No assistance was provided. R8 poked her sandwich three more times with her fork, pierced another small piece of bread and ate it. R8 coughed while eating the bread. When R8 pierced a half dollar sized piece of meat (turkey) on her fork, it couldn't fit in her mouth so she ate it with her fingers. NA-A was standing next to R8 but did not offer assistance to R8. No staff offered assistance as R8 continued to clear her throat and cough. Staff did not provide and/or offer assistance until 12:27 p.m. when AS-A moved R8 closer to the tray and then left the immediate area. At 12:28 p.m. NA-B assisted R8 with eating while she stood next to her. NA-B offered R8 a few bites of food and then walked away from the table.

It was observed on 10/26/15, at 12:45 p.m. that R8 had a Kleenex in her mouth and was chewing on it. Since the staff in the dining room did not notice, the surveyor alerted staff to the situation. NA-A left the resident she was feeding, came to R8 and retrieved the Kleenex at 12:49 p.m. It was noted there was a large piece of Kleenex and a smaller one removed from her mouth.

The following day, on 10/27/15, at 11:59 a.m. R8 was transported to the dining room for the noon meal. R8 was positioned on the left side of her buttocks and thus facing away from the table. R8's feet were on the foot pedal extended perpendicular to the table. R8 was offered a sip of water by NA-A and then NA-A walked away from the table. R8 continued to try to reach her

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food many times but was unable. R8 finally put her arm in the dish of food. No staff offered R8 a tray table so that her food could be reached. There were nine staff located in the dining room. At 12:04 p.m. NA-A and AS-A pulled R8 up in the wheelchair with the use of the Hoyer canvas located underneath the resident. When staff pulled R8 up in the chair, she remained facing in the direction away from the table. At 12:11 p.m. registered nurse (RN)-A asked R8 how she was doing. R8 did not answer but moans in response. R8 wiggled her buttocks in the wheelchair and started calling out "mr., mr." and then reached for her food again. No one responded to her calling out nor the squirming. R8 placed her clothing protector onto her plate of food. On 10/27/15, at 12:16 p.m. RN-A and NA-D transported R8 from the dining room to her room.

When interviewed on 10/27/15, at 12:20 .p.m. NA-A stated R8 is not typically fed her meals.

It was observed on 10/27/15, at 6:09 p.m. that R8 was lying in bed. R8 had slid down in bed, her head was off the bed which was up (elevated). R8's food is located on the overbed table, the plate cover is off the food and a clothing protector has been applied when the meal/set up occurred. The table was level with R8's forehead. A dish of fruit cocktail with juice was located on the tray. R8 was not able to reach her silverware so picks up the fruit with her fingers and drinks the juice from the bowl. R8 continued to eat the fruit cocktail, a piece at a time, pouring the fruit into her mouth. The surveyor informed the director of nursing (DON).

At 6:16 p.m. the DON arrived and fed R8, who ate well without complaints even though the DON

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F 311	Continued From page 12 indicated R8 usually didn't like being fed. The DON lowered the overbed tray to the appropriate level and fed R8. When asked the staff expectation for assisting and positioning residents, the DON indicated the noted situation was not how she expected residents to eat and/or be positioned. When interviewed on 10/28/15, at 8:39 a.m. NA-G stated R8 normally doesn't get help eating. When interviewed on 10/28/15, at 12:49 p.m. registered occupational therapist (OTR)-B stated R8 should be sitting at a 45-50 degrees angle while eating in bed and that speech therapy recommends that R8 sit upright 30 min. after eating. A facility policy was requested but not received.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure adequate assistance was implemented to prevent further falls for 1 of 2 residents (R29) reviewed for accidents.	F 323	R29 □ Care plan has been updated to reflect transfers with 1 assist. Education was given to nursing staff on 11-19-15 to ensure that staff were providing the care needed to keep	11/19/15

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F 323	Continued From page 13 Findings include: R29 was admitted on 8/3/11, and the Diagnosis Report located in the medical record indicated R29 had diagnoses including: peripheral vascular disease, hereditary and idiopathic neuropathy, malaise, anemia, chronic pain, macular degeneration, restless leg syndrome and anxiety disorder. R29's quarterly Minimum Data Set (MDS) dated 10/21/15, identified R29 as requiring extensive assistance for bed mobility, transfer, locomotion off unit, dressing and toileting. R29 was identified as having a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. R29's Fall Risk Assessments identified a 19 score on 2/26/15, a 17 score on 4/30/15 and a 19 score on 5/21/15, indicating a high risk for potential falls. R29's care plan dated 8/11/15, identified R29 as having a history of falls including sustaining a left femur fracture with a fall on 12/5/13. Additional risk factors for falls included R29 needing assistance with activities of daily living (ADL's), use of assistive devices, medications including antidepressants, occasional bladder incontinence, increased pain, neuropathy in feet, decreased vision, episodes of falling asleep in the wheelchair and balance issues during transitions. Interventions included: (1) limited to extensive assistance of 1 for toileting, (2) extensive assistance of 1 for transfers, (3) commode at bedside, (4) encourage use of call light and provide safe environment, (5) make sure wheelchair is locked at night next to bed and during the daytime naps, (6) use of self release	F 323	residents safe. Rounding on all residents was discussed and increased rounding on those residents that are determined high risk. DON or designee will be responsible and monitor on a weekly basis those residents at high risk. DON or designee will monitor residents care planned to be at high risk once a week for a month, once every two weeks for two months and once a month for three months. The results will be reported to the QA committee.	

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belt in wheelchair that is able to apply and remove, and (7) offer to lay down if falling asleep in wheelchair.

Record review identified R29 as having falls on the following dates:
(1) Fall on 1/18/15, at 11:10 a.m. R29 was found on the floor in her room in a sitting position. R29 stated she fell asleep in her wheel chair and slid out of it. R29 denied any injuries.

(2) Fall on 2/2/15, at 2:35 a.m. R29 was found sitting up on the floor and R29 stated her eyes closed while sitting on the commode and the next thing she was falling. R29 denied any injuries.

(3) Fall on 2/26/15, at 5:30 p.m. R29 was found on the floor and R29 stated she was transferring to her chair from her wheel chair and slipped on a pillow that had fallen on the floor. R29 stated she slid down the front of her chair to the floor. R29 denied any pain or injuries.

(4) Fall on 5/21/15, at 5:10 p.m. R29 was heard calling out from her room and she was found on the floor by her recliner. R29 stated she was transferring to her wheel chair but couldn't get turned around. R29 had a red/purple hematoma on her forehead and a 1 centimeter (cm) v-shaped skin tear on her right elbow and bruising on both knees. R29 complained of pain in her head, right shoulder, right elbow and both knees. R29 was taken to the emergency department and then returned to the facility.

(5) Fall on 5/30/15, at 7:15 a.m. R29 was yelling for help and was found sitting on the floor beside her bed with her legs underneath the bed. R29 explained she was transferring from the

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commode to the wheelchair and sat down on the floor. R29 denied any injuries.

(6) Fall on 10/5/15, at 4:15 p.m. R29's Fall's Event Report dated 10/5/15, indicated the nature of the incident as a fall during one assist while transferring from toilet to wheelchair. The report indicated the root cause of the fall was R29's legs and knees giving out and staff unable to keep R29 from falling. The report indicated the initial intervention to prevent future falls included having another staff member assist with transferring off the toilet to the wheelchair.

(7) Fall on 10/20/15, at 4:53 p.m. indicated R29 was found sitting on the floor next to the bed after trying to transfer self to the bed. No Falls Event Report was available for this fall.

The communication book lacked documentation indicating R29 required two staff for toileting following the fall dated 10/5/15.

When interviewed on 10/28/15, at 12:45 p.m. nursing assistant (NA)-E stated R29 requires one assist for toileting. NA-E also stated the NA's get their information regarding any changes in resident cares from the communication book and it is passed on at shift reports.

During an interview on 10/28/15, at 1:21 p.m. registered nurse (RN)-B stated interventions are put into place immediately the day the fall occurs. RN-B stated she wasn't aware of the initial intervention for two staff to transfer R29 during toileting, following the fall on 10/5/15. RN-B confirmed the care plan hadn't been updated therefore the NA's wouldn't be aware of the change.

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F 323	Continued From page 16 During an interview on 10/28/15, at 1:40 p.m. the director of nursing (DON) confirmed she wasn't aware of the intervention that was to have been added to the care plan, and also confirmed there had been no changes to the care plan following the fall on 10/5/15. The DON also confirmed no incident report could be found following the fall on 10/20/15. During an interview on 10/29/15, at 10:19 a.m. NA-F stated R29 requires one person to assist with toileting due to poor balance. NA-F confirmed she wasn't aware of any changes in R29's care plan. Review of Mayo Clinic Health System Patient Falls Policy and Procedure for Post-Fall Care of Patient and Documentation with revised dated of 3/20/15, indicated: Document in Electronic Medical Record plan of care to include interventions to prevent further falls based on risk assessment.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		11/17/15

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F 329	Continued From page 17 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to adequately monitor and document the indications for the continued use of an antidepressant for 1 of 5 residents (R35) reviewed for unnecessary medication use. Findings include: The quarterly Minimum Data Set (MDS) dated 9/6/15, indicated R35 had moderate cognitive impairment and required extensive assistance with all activities of daily living (ADL) and supervision and cueing for eating. R35 had no behaviors. The care plan dated 9/28/15, R35's indicated "resident chooses to stay in her room. She enjoys independent activities of reading large print books, looking out her window, visiting with her roommate and watching TV in the evening." Interventions included-continue inviting R35 to special parties/events. R35 has physician ordered Zoloft (an antidepressant) every day at	F 329	R35 Consultant Pharmacist sent note to provider to reassess for use of antidepressant. Meeting held with Consultant Pharmacist and IDT on 11-17-15. IDT will monitor residents weekly at the IDT meeting and alert pharmacist of any changes in resident conditions that ate receiving psychoactive medications. Meeting held with Consultant Pharmacist and IDT on 11-17-15. IDT will monitor residents once a week for a month, once every two weeks for two months and once a month for three months. The results will be reported to the QA committee as well as discussed at the IDT meetings. DON or designee will be responsible to monitor this process.	

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bedtime.

On 10/28/15, at 7:12 a.m. R35 was sitting in her recliner sleeping, with the television on.
At 7:56 a.m. R35 was sitting in the recliner in her room with the call light on the floor. When questioned, R35 offered no complaints.

When interviewed on 10/29/15, at 10:22 a.m. trained medication assistant (TMA)-B stated they monitor R35 for behavior symptoms which include the resident trying to get up by herself. Registered nurse (RN)-C stated the nursing assistants monitor resident behavior and document it on the green sheets. When reviewed, RN-C agreed the sheets from January thru October 2015 did not list any documented behaviors/mood. RN-B stated the computer program does not list any documented behaviors for the weeks of 10/29/15, 10/24/15, 10/17/15 but R35 did have behaviors dated 10/3/15 which included yelling.

When interviewed on 10/29/15, at 10:41 a.m. nursing assistant (NA)-E stated staff don't monitor R35 for any behavior symptoms in particular and indicated that R35 doesn't really have any behaviors. NA-E further stated the sheets identified to monitor behaviors related to R35 coming out of her room; but indicated that all the forms say that.

When interviewed on 10/29/15, at 10:50 a.m. pharmacist (P)-D and P-E confirmed R35 only takes Zoloft. P-D stated she reviews R35's medical record every month and that a note from the physician dated August 2013, indicated it is clinically contraindicated for a dose reduction (Zoloft). No attempt to taper and/or reduce the

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F 329	Continued From page 19 dose was documented in the record nor was justification for continued use available for review since the physician progress note (2 years ago). The behavior sheet from January thru October 2015, indicated no behaviors. The documented behavior symptom that staff were to monitor included "refused to come out of room for meals". The behavior sheets listed Zoloft as the only medication administered for R35. An interview with the director of nurses (DON) on 10/29/15, at 1:23 p.m. stated there isn't any mood monitoring. The DON stated that R35 is 102 years old and she may verbalize she wants to die but there is not documentation related to that behavior symptom. A written document from P-D requesting a dose reduction was dated 8/16/13; the physician responded that it was clinically contraindicated at the time but no further requests for a dose reduction/taper have been documented.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		11/17/15

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F 428	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation ,interview and document review the facility failed to ensure pharmacy reviews identified the need for the continued use/dose of an antidepressant medication for 1 of 5 (R35) residents reviewed for unnecessary medications. Findings include: The quarterly Minimum Data Set (MDS) dated 9/6/15, indicated R35 had moderate cognitive impairment and required extensive assistance with all activities of daily living (ADL) and supervision and cueing for eating. R35 had no behaviors. R35 has physician ordered Zoloft (an antidepressant) every day at bedtime. When interviewed on 10/29/15, at 10:50 a.m. pharmacist (P)-D and P-E confirmed R35 only takes Zoloft. P-D stated she reviews R35's medical record every month and that a note from the physician dated August 2013, indicated it is clinically contraindicated for a dose reduction (Zoloft). P-D indicated she does not look for behavior symptoms when reviewing the latest progress notes. No attempt to taper and/or reduce the dose was documented in the record nor was justification for continued use available for review since the physician progress note (2 years ago). The behavior sheet from January thru October 2015, indicated no behaviors. The documented behavior symptom that staff were to monitor included "refused to come out of room for meals". The behavior sheets listed Zoloft as the only medication administered for R35.	F 428	R35 □ Consultant Pharmacist sent note to provider to reassess for use of antidepressant. Meeting was held with Consultant Pharmacist on 11-17-15 to discuss monthly drug reviews, that providers need to be notified of any irregularities. DON or designee will be responsible for monthly monitoring.	

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F 428	Continued From page 21 An interview with the director of nurses (DON) on 10/29/15, at 1:23 p.m. stated there isn't any mood monitoring. The DON stated that R35 is 102 years old and she may verbalize she wants to die but there is not documentation related to that behavior symptom. A written document from P-D requesting a dose reduction was dated 8/16/13; the physician responded that it was clinically contraindicated at the time but no further requests for a dose reduction/taper have since been documented.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		11/19/15

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F 441	Continued From page 22 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure glucometers were properly cleaned after use for 3 of 5 residents (R32, R42, R65) observed when blood sugar levels were tested; failed to implement infection control procedures for 4 of 4 residents (R2, R5, R22, R61) who required special contact precautions; failed to ensure proper handwashing was implemented during 1 of 4 resident (R1) cares observed and failed to ensure the facility pet was not allowed in the dining room during meals. Findings include: On 10/28/15, at 8:08 a.m. trained medication aide (TMA)-A was observed to test three residents' blood with a multi use glucometer. TMA-A did not appropriately cleanse the machine following use. Resident's whose blood sugars TMA-A checked with the glucometer were R11, R32, and R42. Although the glucometer machine never came in	F 441	Roger Drahota, Infection Control Nurse, gave an inservice and discussed glucometer cleaning, hand washing and glove use and contact precautions. Facility pet should not be in the dining room when residents are eating. Glucometers have been thoroughly cleaned and staff have been shown how to clean properly going forward. DON will report to QA committee quarterly. DON or designee will be responsible for monitoring glucometer cleaning, hand washing and glove use, implementation of infection control procedures and facility pet being in the dining room during meal time. A boundary will be put up during meal hours to keep facility pet from entering the dining space during meals. The activity director will report progress to the QA committee.	

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contact with any of the resident's skin, the TMA-A did not clean the glucometer between use. Instead, following each blood sugar check, TMA-A placed the glucometer into the machine's case. When she had completed R42's blood glucose check, TMA-A handed the case to licensed practical nurse (LPN)-D. TMA-A did not inform LPN-D she had not cleaned the glucometer.

At approximately 8:25 a.m., LPN-D took the same glucometer into R65's room to check the resident's blood sugar. Following the glucometer check, LPN-D proceeded to clean the glucometer. At 8:29 a.m. LPN-D stated she cleans the glucometer after every use. She said she does not clean it prior to use because the machine should be cleaned after use and prior to being stored in the case.

When interviewed on 10/28/2015, at 8:33 a.m. registered nurse (RN)-C said it is the facility's expectation that glucometers be cleaned after each use and prior to storage in the case.

When interviewed on 10/28/2015, at 8:35 a.m. TMA-A acknowledged the glucometer should be cleaned after each use.

During an interview on 10/28/2015, at 8:41 a.m. RN-D/infection control preventionist verified this need for glucometers to be cleaned. and stated, it would normally be safe to assume the machine is clean when it is removed from the case because the machine should be clean prior to being put into the case.

When interviewed on 10/28/2015, at 8:50 a.m. the director of nurses (DON) confirmed the

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expectation is for the glucometer to be cleansed after each use and before placement into the case in accordance with facility policy. A facility policy was requested but not received.

During the initial facility tour on 10/26/15, at 10:34 a.m. it was noted that four resident rooms (R2, R5, R22, R62) had personal protective equipment (PPE) located outside the rooms adjacent to the door. However, there was no information indicating the need to check with nursing staff prior to entering the room.

When interviewed on 10/26/15, at 3:32 p.m. registered nurse (RN)-D stated there should be signs posted by the residents rooms alerting staff /visitors of special infection control precautions. RN-D stated the normal practice is to post signs informing staff if they need to use gowns/gloves while working with the residents. During a tour of the hallways, RN-D confirmed there was PPE located outside the rooms but no signs indicating the residents required special precautions. RN-D confirmed there should be signage and added the policy indicated there should be signs posted indicating the type of precautions staff were to follow.

When interviewed on 10/26/15, at 3:45 p.m. the director of nursing (DON) confirmed there should be signs posted related to special precautions.

During observation of morning cares on 10/28/15, at 7:50 a.m. nursing assistant (NA)-G was observed assisting R1 from the bed to the toilet. NA-G donned gloves and removed R1's incontinent product. NA-G then removed the gloves and without washing her hands proceeded to make R1's bed while R1 remained seated on

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MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

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F 441	Continued From page 25	F 441		

the toilet. NA-G then retrieved pants from R1's closet and assisted R1 with applying the pants. NA-G then donned gloves and provided peri care to R1 followed by putting barrier cream on R1's peri-area. NA-G then removed the gloves and without washing her hands she put on a new incontinent product for R1 and assisted R1 back to her recliner where NA-G changed the oxygen tubing from the portable oxygen to the oxygen concentrator and finished dressing R1. NA-G provided R1 with her glasses and call light and then NA-G returned to the bathroom to finish cleaning. When questioned about washing her hands while providing cares, NA-G stated she would wash her hands; however, she wasn't finished cleaning up R1's bathroom yet. NA-G indicated she would wash her hands when tasks for R1 were completed.

During interview on 10/29/15, at 8:56 a.m. registered nurse (RN)-D stated all staff are provided education on hand washing when they are hired and then on a yearly basis. RN-D also confirmed the NA should have implemented the handwashing protocol for washing hands after removal of contaminated gloves.

Review of the Lutz Wing Infection Prevention and Control Guideline-Fairmont dated 10/28/15, indicated gloves will be removed, discarded and replaced with a new pair after hand hygiene is completed.

On 10/28/15, at 9:29 a.m. it was observed that the facility pet dog was walking around the dining room and under the tables eating spilled food off the floor while residents were eating their breakfast.

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F 441	Continued From page 26 During interview on 10/28/15, at 9:29 a.m. nursing assistant (NA)-A stated she wasn't aware the dog couldn't be in the dining room. NA-A also stated the residents will give the dog some of their food and the dog has gained seven pounds since they have had it in the facility. During interview on 10/28/15, at 9:35 a.m. the DON stated the dog has been gaining weight and she confirmed the dog should not be allowed in the dining room during meal times. During review of the Mayo Clinic Health System Lutz Wing Activity Policy: Pet Therapy/Pets in the Care Center-Fairmont dated 10/19/15, included the following policy statement: *Pet animals are not allowed in kitchen areas, medication storage areas, clean or sterile supply storage areas or in the dining room during meals.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a functioning call system was available for use for 1 of 8 residents (R35) observed who utilized call lights. Findings include: During an observation on 10/27/15, at 1:48 p.m.	F 463	Nursing staff was given education on 11-19-15 that call lights should be checked when giving cares to residents in the am and HS. The call light can be turned on and checked on the staff's pager to see that the call light is working properly. The HUC was reminded to update and do	11/24/15

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F 463	Continued From page 27 R35's call light was not located within her reach. The call light was located on a chair, and R35 was resting in the bed. The chair was located three (3) feet from the bed. After the call light was activated, it did not work. Registered nurse (RN)-A verified the call light was not within R35's reach and was non-functioning. RN-A stated, "it is too bad the call light wasn't in reach because she uses it all the time." RN-A indicated he was unaware of how long it had been since the call light worked. The ward clerk stated that according to the call light log document, the call light had not been activated since 10/23/15. The call light was subsequently repaired. When interviewed on 10/28/15, at 1:34 p.m. facilities manager (FM)-G stated there is no preventative maintenance plan to routinely check the resident call light system but only repaired it as a work order was submitted. An interview on 10/28/2015, the director of nursing (DON) stated she was unaware that R35's call light was not functioning properly. A facility policy was requested but not received.	F 463	system maintenance as indicated by the program. DON or designee will be responsible for monitoring the call light checking. Call light low battery report will be viewed by the IDT staff once a week for a month, once every two weeks for two months and once a month for three months. The results will be reported to the QA committee. Staff will also check the call lights to ensure they are in proper working order throughout the week. Staff will have batteries available to fix dead battery call lights.	

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 28, 2015. At the time of this survey, Mayo Clinic Health System Fairmont was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 11/27/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mayo Clinic Health System Fairmont was constructed as follows: The original building was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction; The 1990 building Addition is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 35 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based upon a review of available records, it was determined the facility had failed to conduct one or more quarterly fire drills during the previous year, in accordance with NFPA 101 (2000) Chapter 19, Section 19.7.1.2. In a fire emergency, this deficient practice could adversely affect all patients, staff and visitors throughout the	K 050	Facilities held a fire drill at Lutz Wing on 10-30-15. Facilities will hold fire drills at unexpected times under varying conditions at least quarterly on each shift at Lutz Wing. Facilities will be responsible for holding the fire drills and will monitor that these are being done, the results will be shared with the Quality Assurance Committee.	10/30/15

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K 050	Continued From page 3 facility. FINDINGS INCLUDE: On 10/28/15 between 9:30 AM and 11:30 AM, while reviewing fire drill reports provided by facility staff, it was confirmed that fire drills were not being conducted as required. The last documented fire drill conducted separately in the Nursing Home was on 09/25/2014.	K 050		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain an egress corridor free from impediments to full instant use in the case of fire or other emergency, in accordance with NFPA 101 (2000), Chapter 7, Sections 7.1.10.1 and 7.1.10.2.1, and, the 2007 edition of Minnesota State Fire Code (MSFC) Chapter 10, Section 1028. In an emergency evacuation situation, these impediments could interfere with the prompt and orderly evacuation of 35 of 35 residents, staff and visitors. FINDINGS INCLUDE: On 10/28/15 at 10:30 AM, observation revealed a	K 072	On 10-28-15 an email was sent to nursing staff at Lutz Wing that hallways cannot be used as a storage area. Items were removed from the hallways. DON or designee is responsible for monitoring this on a daily basis. DON or designee will check the hallways for equipment once a week for a month, once every two weeks for two months and once a month for three months. The results will be reported to the QA committee.	10/28/15

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K 072	Continued From page 4 patient lift, a clean linen cart, desk, and several wheelchairs being stored in all egress corridors. This storage arrangement was not in conformance with NFPA 101 (00) Chapter 7 and the 2007 edition of Minnesota State Fire Code (MSFC) Section 1028. This finding was confirmed with the facility's chief building engineer (KB) at the time of discovery.	K 072		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:30 AM and 11:30 AM on 10/28/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system.	K 154	K155 We have a Fire Watch policy but the policy states we will enact the policy if the sprinkler system is to be down, or goes down, for any length of time greater than 4 hours in a 24 hour period, we will enact our fire watch policy until the known outage is repaired. This policy will be implanted by the facilities staff and the QA committee will be notified of any instances where the policy is enacted.	10/30/15

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K 154	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director (KB) at the time of discovery.	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:30 AM and 11:30 AM on 10/28/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 155	K155 We have a Fire Watch policy but the policy states we will enact the policy if the sprinkler system is to be down, or goes down, for any length of time greater than 4 hours in a 24 hour period, we will enact our fire watch policy until the known outage is repaired. This policy will be implanted by the facilities staff and the QA committee will be notified of any instances where the policy is enacted.	10/30/15