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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C9XP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00770

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245218**
2.STATE VENDOR OR MEDICAID NO.
(L2) **715522100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAYO CLINIC HEALTH SYSTEM - LAKE CITY**
(L4) **500 WEST GRANT STREET**
(L5) **LAKE CITY, MN** (L6) **55041**

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 **05/26/2015** (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 **90** (L18)

13.Total Certified Beds **90** (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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(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 :
Gary Nederhoff, Unit Supervisor 05/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/14/2015 (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
03/20/1978
(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)

Posted 07/15/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245218

July 14, 2015

Mr. Jacob Suckow, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, Minnesota 55041

Dear Mr. Suckow:

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 May 18, 2015 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 26, 2015

Mr. Jacob Suckow, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, Minnesota 55041

RE: Project Number S5218024

Dear Mr. Suckow:

On April 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 21, 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 April 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2015, effective May 18, 2015 and therefore remedies outlined in our letter to you dated April 20, 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
Division of Compliance Monitoring
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
245218	A. Building B. Wing	5/26/2015

Name of Facility	Street Address, City, State, Zip Code
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **05/18/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/18/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/18/2015**	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	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	GPN/kfd	05/26/2015	10160	05/26/2015
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
4/10/2015			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245218	01 - MAIN BUILDING 01	5/21/2015

Name of Facility	Street Address, City, State, Zip Code
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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 Reg. # **NFPA 101** LSC K0056	Correction Completed **05/18/2015**	ID Prefix Reg. # **NFPA 101** LSC K0076	Correction Completed **05/18/2015**	ID Prefix Reg. # **NFPA 101** LSC K0147	Correction Completed **05/18/2015**
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
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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	05/26/2015	25822	05/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/7/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C9XP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00770

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(L1) **245218**
2.STATE VENDOR OR MEDICAID NO.
(L2) **715522100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAYO CLINIC HEALTH SYSTEM - LAKE CITY**
(L4) **500 WEST GRANT STREET**
(L5) **LAKE CITY, MN** (L6) **55041**

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 **04/10/2015** (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 **90** (L18)

13.Total Certified Beds **90** (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
	90			
(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 :
Lisa Carey, HFE NE II 05/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/26/2015 (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
03/20/1978
(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
April 20, 2015

Mr. Jacob Suckow, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, Minnesota 55041

RE: Project Number S5218024

Dear Mr. Suckow:

On April 10, 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 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 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 May 20, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 20, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 July 10, 2015 (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 October 10, 2015 (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 electronic 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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 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
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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		5/18/15

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

Electronically Signed | 05/18/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING _____ B. WING _____	04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice on a timely manner prior to termination of Medicare skilled services for 3 of 3 residents (R48, R20, and R64) reviewed for liability notice and beneficiary appeal rights. Findings Include: R48 was discontinued with therapy and Medicare services on 1/19/2015. On 1/19/2015 the facility provided the Skilled Nursing Facility Advance Beneficiary Notice and the Notice of Medicare Non-Coverage. R48 was to remain at the nursing facility under custodial care. During an interview on 4/10/15 at 9:45 a.m. registered nurse (RN)-A stated the facility had notified the family of the discontinuation of Medicare services, but had	F 156	April 14, 2015, MDS Nurse was educated to provide the resident both verbally and in writing the liability notice prior to the discharge from Medicare services. April 14, 2015 MDS Nurse implemented a written tracking form for verbal and written liability notices. Auditing will be done by DON weekly on each resident who is discharged from Medicare services for 3 months.	

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F 156	Continued From page 3 not documented the phone call. RN-A stated the written notice was not provided to R48 until the day the services ended. However, the notification should have been at least two days before covered services would end. R20 lacked a notice of discontinuation of Medicare services. R20 did not receive the Skilled Nursing Facility Advance Beneficiary Notice or the Notice of Medicare Non-Coverage. R20 started with therapy on 11/19/14 and was discharged from therapy on 12/5/14. R20 was discharged to home on 12/6/14. During an interview on 4/10/15 at 9:45 a.m. RN-A stated she thought that she had provided a notice to R20 and R20's family, but was unable to locate the notice. R64 lacked a notice of discontinuation of Medicare services. R64 did not receive the Skilled Nursing Facility Advance Beneficiary Notice or the Notice of Medicare Non-Coverage. R64 had a therapy start of care date of 8/19/14 and was discharged from therapy on 11/25/14. Social Services note dated 11/25/14 documented a discharge plan for 11/26/14. The social services notes did not identify the discontinuation of therapy services or Medicare services. During an interview on 4/10/15 at 9:45 a.m. RN-A stated she thought that she had provided a notice to R64 and R64's family, but was unable to locate the notice. During the interview on 4/10/15 at 10:00 a.m., RN-A stated she did not have a system to ensure the notices were returned to the facility and filed in the resident's permanent record.	F 156		
F 278	483.20(g) - (j) ASSESSMENT	F 278		5/18/15

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F 278 SS=D	Continued From page 4 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to correctly document behavioral symptoms on the Minimum Data Set (MDS) for 1 of 2 residents (R68) reviewed for behavioral and emotional well being during the course of the survey.	F 278	April 14, 2015, MDS Nurse and other RN who complete MDS, were educated that whether the MDS assessments are manually completed, or computer generated following data entry, each individual assessor is responsible for	

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F 278	Continued From page 5 Findings include: R68's admission MDS, dated 11/17/14, identified R68 had intact cognition, and demonstrated no physical behavioral symptoms (hitting, kicking, pushing, scratching) directed towards others. R68's quarterly MDS, dated 1/28/15, identified R68 remained cognitively intact, but now demonstrated physical behavioral symptoms towards others "1 to 3 days" during the reference period. R68's Behavior Summary Report, dated 1/28/15, did not identify any recorded episodes of physical behavioral symptoms from 1/22/15 to 1/28/15. R68's progress notes, dated 1/22/15 to 1/28/15 did not identify any documented physical behaviors by R68. During interview on 4/9/15, at 9:06 a.m. registered nurse (RN)-A stated the facility used a point-of-care charting system, and sometimes wrong information is pulled to the MDS as a result. Further, the nurse who signed R68's MDS was no longer at the facility, but the MDS should have been reviewed for accuracy before being signed as completed. When interviewed on 4/9/15, at 1:56 p.m. the director of nursing (DON) stated R68 has had no physical behaviors to her knowledge. Further, R68's MDS should have been completed accurately, and not included coding for physical behavioral symptoms. An undated facility Resident Assessment Instrument (MDS) policy, identified a purpose which included, "To ensure a comprehensive	F 278	certifying the accuracy of responses relative to the resident¿s condition and discharge or entry status. RN who completed R68 MDS has terminated from employment here at the care center. Auditing will be done by DON/or Quality Director on behavioral symptoms on up to 6 MDS¿s weekly completed for 3 months.	

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F 278	Continued From page 6 assessment of a resident's needs is done in compliance with the state and federal regulations..." and further identified a procedure step of, "All persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information."	F 278		
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 observation, interview, and document review, the facility failed to ensure safe use of a rolling wheeled seated walker for 1 of 1 resident (R32) with a rolling walker. Findings include: During observations on 4/7/15, at 12:40 p.m., R32 was seated on a four wheeled walker as licensed practical nurse (LPN)-B pushed the resident from the nurses ' desk to R32's room located near the end of the hall. LPN-B stated R32 sat on her wheeled walker seat by the nurse's desk due to leg pain and asked to be pushed to her room. LPN-B stated the purpose of the wheeled walker seat was for sitting on.	F 323	April 13, 2015, Nurse that pushed in rolling wheeled seated walker was educated to not push a resident using the rolling wheeled seated walker. List of residents who have seated walkers was compiled. Education with all nursing staff done on Assistive devices that are not used properly (per manufacturer¿s specifications) may cause a risk or hazard to a resident. Education added to the Preceptor sheets for all new nursing staff employees. Therapy will annually and as needed in-service nursing staff about Assistive devices being used properly. Auditing will be done by Nurse Managers	5/18/15

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F 323	Continued From page 7 R32's quarterly Minimum Data Set (MDS), dated 1/28/15, identified R32 had moderately impaired cognition, independent ambulation in room and hallway, no falls since prior assessment, and received no therapies. Document review of the facility quarterly fall risk assessment dated 1/29/15, identified R32 had no falls since prior assessment, had history of falls, and was at risk for falls. The assessment identified R32 received psychotropic and diuretic medication, side effects and target behaviors were monitored daily, was independent with transfers and mobility with her four wheeled walker. Document review of R32 ' s care plan dated 11/5/13, revealed a focus of alteration in mobility related to abnormal gait. Interventions included independent in bed mobility, transfers, and ambulation throughout the facility with four wheeled walker. During interview on 4/8/15, at 10:45 a.m., director of nursing stated she expected staff to not push residents seated on the wheeled walker. Director of nursing verified the facility did not have a policy for use of the wheeled walker. During interview on 4/8/15, at 11:10 a.m., physical therapist (PT)-A stated it was not safe to push residents seated in a wheeled walker. During interview on 4/8/15, at 1:00 p.m., director of nursing provided the manufacturers' instructions for Drive Rollator wheeled walker. Director of nursing verified the following instructions Important Safety Notice read, "Do not have anyone push you while you are seated on	F 323	and Charge Nurses 3 times a week for 4 weeks.	

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F 323	Continued From page 8 the Rollator. This is a walking aid only and is not to be used as a transportation device." During interview on 4/9/15, at 1:26 p.m., director of nursing stated R32 had no falls in the past three months.	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 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 record	F 329	May 18, 2015, A sleep summary form	5/18/15

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F 329	Continued From page 9 review, the facility failed to complete a sleep assessment for 2 of 2 residents (R40, R60) who received sleep medications. Findings include: R40 received Ambien for sleep nightly, but lacked a sleep reassessment to determine continued need for the hypnotic. R40 was observed on 04/08/2015 1:09 p.m. lying in bed and covered with blankets. R40 stated that she would be in her bed all afternoon. R40 remained in bed at 3:15 p.m. The director of nursing provided documentation indicating R40 had received Ambien since 2011. On 8/3/13 the physician increased the Ambien to 10 mg nightly and on 11/6/13 the physician wrote to give 1 tablet by mouth at bedtime related to insomnia. On 12/11/14 the facility completed a pain assessment. The pain assessment indicated that no changes in sleep pattern had occurred because of pain. The annual Minimum Data Set dated 2/9/15 was reviewed. The MDS indicated a BIMS (brief interview of mental status) score was 15 out of a possible 15 or no cognitive impairment. The MDS indicated R40 denied trouble falling or staying asleep. The director of nursing (DON) was interviewed on 4/9/15 at 1:35 p.m. and stated the facility did not complete a sleep assessments, but would check to see if sleep was part of any other assessment. On 4/9/15 at 2:02 p.m. the DON stated the pain	F 329	was instituted which will be done with all residents on admission, quarterly, significant change, and prn who are receiving a hypnotic medication. A sleep summary form was done on R40. Resident R60 has passed away. Sleep summary forms will be done on all residents who receive a hypnotic medication during the next 3 months. Interdisciplinary Team will review each sleep summary form with interventions and update care plan. At each care conference, sleep summary form will be reviewed with resident and family. DON will audit that a sleep summary form was done with each MDS on a resident who is receiving a hypnotic medication for 3 months. DON will audit that resident is being monitored 24 hours a day for 7 days before sleep summary form is completed.	

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F 329	Continued From page 10 assessment mentioned sleep, but no current sleep reassessment was found. R60 lacked a comprehensive sleep assessment to determine the need for a hypnotic medication. R60's quarterly Minimum Data Set (MDS) dated 1/19/2015 included but was not limited to diagnoses of chronic myeloid leukemia, depression, anxiety disorder, chronic pain syndrome, spasms of muscle, and insomnia. The MDS indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 15 and the resident mood interview (PHQ-9) indicated R60 did not have trouble falling or staying asleep, or sleeping too much. R60's signed physician's orders dated 2/19/15 included; Ambien (sleep medication) 12.5 milligram (mg) extended release by mouth as needed for inability to sleep with a start date of 12/10/15 and Mirtazapine (anti-depressant medication with an off labeled use for insomnia) 45 mg via PEG-tube (feeding tube) or by mouth at bedtime for insomnia and depression with a start date of 5/614. A comprehensive sleep assessment that identified usual sleep patterns and potential reasons or risks that would cause sleep disturbances and non-pharmacological interventions were requested and none provided. During an interview on 4/9/15, at 3:30 p.m., director of nursing (DON) explained the facility does not do a comprehensive sleep assessment. DON stated there was one question on the pain assessment pertaining to sleep and the resident is asked on admission what time they would like to go to bed and what time they would like to get up and the facility tracked hours of sleep.	F 329		

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	245218	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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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. At the time of this survey, Mayo Clinic Health System - Lake City was found not 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., 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		05/18/2015

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 and 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. The Mayo Clinic Health System - Lake City was original built in 1977. The facility it is a 1-story building and was determined to be of Type 1 (332) construction. In January 2003, the chapel addition was built and was determined to be of Type I (332) construction. There is no basement in either buildings. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed has one building. . The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 85 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET** **LAKE CITY, MN 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
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to installed the fire sprinkler system in accordance with the requirements of 2000 NFPA 101 Chapter 19.3.5 and 9.7 and 1999 NFPA 13, 7-2.3.2.4. The deficient practice could affect 25 out of 85 residents. FINDINGS INCLUDE: On facility tour between 8:30 AM and 12:15 PM on 04/07/2015, observation revealed that in the main lobby area open to the corridor has standard response and quick response sprinkler heads intermixed.	K 056	Automatic sprinklers/instillation - Sprinkler head were changed out bon 5/11/15 by Olympic Fire Protection- Corp. to achieve compliance on 5/11/15.	5/18/15

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	245218	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET** **LAKE CITY, MN 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
K 056	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director (TH) at the time of discovery.	K 056		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1 and Chapter 8, Section 8-3.1.1. . This deficient practice could all 85 residents FINDINGS INCLUDE: On facility tour between 8:30 AM and 12:15 PM on 04/07/2015, observation revealed that in oxygen storage rooms # LN 1-673 & # LN 1- 823 the following was found: 1. (5) unsecured "E" cylinders	K 076	Medical gas storage ¿ education on medical gas storage completed with staff and vendors on 5/4/15. Housekeeping staff will audit compliance weekly for 3 months starting 5/4/15. If compliance is not achieved we will continue audits until we have achieved compliance for 3 months running.	5/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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

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K 076	Continued From page 4 2. Empty combustible boxes with-in 5 feet of oxygen cylinders These deficient practices were confirmed by the Facility Maintenance Director (TH) at the time of discovery.	K 076		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70, 110-26. The deficient practice could affect 25 out of 85 residents. Findings include: On facility tour between 8:30 AM and 12:15 PM on 04/07/2015, observation revealed, that the following circuit breaker panels do not have the proper clearance: 1. LN1-653 2. LN1-853 NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the Facility Maintenance Director (TH) at the time of discovery.	K 147	Electrical Code Compliance ¿ Housekeeping rooms containing electrical panels cleaned out and staff educated on 36¿ rule around electrical panels on 4/29/15. Housekeeping staff will audit compliance weekly for 3 months starting 5/18/15. If compliance is not achieved we will continue audits until we have achieved compliance for 3 months running.	5/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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K 147	Continued From page 5 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147		