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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GSPL

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 **12/15/2016** (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:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (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 :
Kathryn Serie, Unit Supervisor 12/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/3/2016 (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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245274

January 3, 2017

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 December 8, 2016 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

December 29, 2016

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

RE: Project Number S5274026

Dear Mr. Corchran:

On November 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 9, 2016. 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 December 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 19, 2016 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 November 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 9, 2016, effective December 8, 2016 and therefore remedies outlined in our letter to you dated November 28, 2016, 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245274 Y1	A. Building B. Wing Y2	12/15/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	12/08/2016	LSC	12/08/2016	LSC	12/08/2016
ID Prefix F0311	Correction	ID Prefix F0314	Correction	ID Prefix F0329	Correction
Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(l)	Completed
LSC	12/08/2016	LSC	12/08/2016	LSC	12/08/2016
ID Prefix F0334	Correction	ID Prefix F0371	Correction	ID Prefix F0441	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.65	Completed
LSC	12/08/2016	LSC	12/08/2016	LSC	12/08/2016
ID Prefix F0466	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/08/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	12/29/2016	03048	12/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/9/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245274 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/19/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0341	12/08/2016	LSC	K0354	12/08/2016	LSC	K0711	12/08/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0712	12/08/2016	LSC	K0918	12/08/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	12/29/2016	35482	12/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/9/2016

☐ 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: GSPL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00359

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2. STATE VENDOR OR MEDICAID NO. (L2) **259845104**

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(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 **11/09/2016** (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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 :
Holly Kranz, HFE NE II 12/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/29/2016 (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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 28, 2016

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

RE: Project Number S5274026

Dear Mr. Corchran:

On November 9, 2016, 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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: 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 January 7, 2017, 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 January 7, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (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 February 9, 2017 (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 May 9, 2017 (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. 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
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	11/09/2016

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		12/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2016

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 _____	11/09/2016

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan related to thrombocytopenia and risk for bleeding/bruising for 1 of 3 residents (R15) reviewed for non-pressure related skin conditions. Findings include: Review of R15's diagnosis report included diagnosis of thrombocytopenia (deficiency of platelets in the blood that causes bleeding into the tissues, bruising, and slow blood clotting after injury). On 11/6/16, at 2:22 p.m. R15 was observed to have two dime sized dark purple bruises with lighter purple bruising around the area approximately 3 centimeters (cm) in diameter. During interview with resident at this time, he stated he obtained the bruises when going through door ways, reaching and bumping right hand. On 11/9/16, at 11:38 a.m. R15 stated "I bruise easy". Review of R15's physician orders dated 9/27/16 included an order for prednisone (a medication used to suppress the immune system with side effect of increased bruising tenancy) 10 milligrams (MG) by mouth in the morning for low platelets (parts in the blood that help the blood clot) and an order on 10/17/16 to decrease prednisone to 7.5 MG daily. Review of R15's laboratory results from 9/6/16 to 10/31/16 indicate weekly platelet levels were drawn. R15's platelet results ranged from	F 279	Care Plan for Resident # 15 was updated to include the diagnosis and interventions to be monitored. Nurses have been informed of expectation that new diagnosis, treatments and changes of condition for any resident will be added to their care plan. Audits will be completed every other week twice, monthly twice, and then quarterly twice to monitor compliance with the care plan policy. Task will be completed by DON or designee. Results of audits will be presented to the QA committee.	

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 _____	11/09/2016

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F 279	Continued From page 2	F 279		

22,000-32,000 per liter (L) with normal reference range of 150,000-450,000 platelets per L. Progress note indicated call from laboratory stating critical low platelet counts of 26,000 per L on 10/17/16.

Review of R15's care plan, revised 10/4/16, identified R15 as being at risk for pressure ulcers with risk factors including previous pressure ulcers, diagnosis, medications, use of a wheelchair (W/C) for primary mode of locomotion, and history of skin irritation. The care plan did not include R15 as being at risk for bleeding/bruising nor reference to the diagnosis of thrombocytopenia nor interventions related to bleeding/bruising.

During interview on 11/9/16, at 7:33 a.m. registered nurse (RN)-B indicated R15 has had a diagnosis of thrombocytopenia for over a year and was being treated with prednisone. Further stated R15 had been having critically low platelet levels. RN-B verified the care plan lacked interventions related to R15's risk for bleeding/bruising, stating "that should've been in there".

During interview on 11/9/16, at 12:50 p.m. director of nursing (DON) stated her expectation is that a care plan is developed when someone has a clotting disorder and risks of bleeding/bruising.

The facility's policy Care Conferences Procedure- dated 4/5/16, indicated care conference day RN assists in developing a written plan of care for each resident that identifies the problems/need of the resident and the goals to be accomplished for each problem/need identified. Facility policy titled Care Conferences Policy- dated 4/5/16 indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 3 care plan components include: problem/need/strength statement, goal statement with target date, interventions/approaches, disciplines involved responsible for each intervention, care plan review and discontinuation dates.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care related to ambulation services for 4 of 4 residents (R28, R6, R15, R8) reviewed for activities of daily living (ADL) and failed to follow the plan of care related to repositioning for 1 of 1 resident (R8) reviewed for pressure ulcers (PU). Findings include: Ambulation: R28's quarterly Minimum Data Set (MDS) assessment dated 8/3/16, identified R28 required extensive assistance of two for transfers and limited assistance of two people for ambulation in the corridor. The MDS identified a diagnosis of non-Alzheimer's dementia. The MDS identified a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). R28's Care Area Assessment (CAA) related to ADL's dated 5/25/16, identified triggers due to	F 282	Resident # 28 - Ambulation was added to care plan and staff instructed on proper way to chart ambulation in PCC. Resident #6 - Staff were instructed on proper way to document that ROM and ambulation were completed. Resident #8 - Ambulation and off loading were added to care plan and staff were instructed on proper way to chart ambulation and off loading. Resident #15 - Ambulation was added to the care plan and staff instructed on the proper way to chart ambulation in PCC. Rehab programs have been added to the care plan and CNAs will chart completion in PCC. Charge nurses will visualize ambulation of residents during their shift and monitor proper charting.	12/8/16

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F 282	Continued From page 4 needing assistance with cares, cognitive impairment and balance issues. R28's care plan last revised 10/4/16, indicated R28 required assistance of one staff with walking and locomotion, using a walker and wheelchair. R28 was to be encouraged to walk to and from meals and activities. R28's daily walking lists, from the previous 30-day period did not include any documented walks/ambulation. R28's physical therapy (PT) discharge instructions dated 3/7/16, indicated R28 was to ambulate to and from the dining room with staff assistance. During observation on 11/7/16, at 12:52 p.m. R28 wheeled himself from the dining room; R28 was not observed to be ambulated from the meal with staff assistance. During interview on 11/7/16, at 12:55 p.m. R28 stated, "There's a few girls that walk me everyday. I need to walk more so I'm not sitting all the time." During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for the noon meal and was not walked in accordance with the recommendation from the PT discharge orders. During observation on 11/8/16, at 12:31 p.m. R28 was observed to wheel himself to and from the noon meal; no staff offered to assist him with ambulation. During observation on 11/8/16, at 12:34 p.m. no	F 282	Nurses have been taught to add ROM, ambulation and off loading to treatment plan in PointClickCare for CNAs to chart and be aware of rehabilitation plans. Nurses will continue to add rehab programs to care plans. Audits will be completed every other week times 2; monthly times 2 and quarterly times 2 to monitor compliance with charting and completing rehab plans for residents. Done by DON or designee. Results of audits will be presented to the QA committee.	

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F 282	Continued From page 5	F 282		

walking program instructions or sheets were observed in R28's room.

During interview on 11/8/16, at 3:30 p.m. the director of nursing (DON) stated that "ambulation is a deficiency of ours," and the facility was attempting to work on improving this task. The DON stated there should be a form inside of the resident's room to document exercise activity. The DON stated that walking to and from meals was during a busy time of day, and consequently another time of the day may work better.

During follow up interview on 11/8/16, at 4:02 p.m. the DON confirmed there was not a walking sheet nor exercise sheet located in R28's room at this time.

During observation of the breakfast meal on 11/9/16, at 8:21 a.m. R28 was observed to wheel himself to the dining room.

During observation of the breakfast meal on 11/7/16, at approximately 8:30 a.m. R6 was not observed to be ambulated to the morning meal.

During observation of the noon meal on 11/7/16, at 1:04 p.m. R6 was wheeled back to the room by visitors and was not offered by staff to ambulate.

R6's face sheet located in the medical record dated 11/8/16, identified diagnoses of osteoarthritis and an artificial right shoulder, as well as history of falls.

R6's care plan last updated 10/31/16, indicated R6 was to be walked- starting 10/31/16 to/from meals and activities with a wheeled walker and assist of one to two staff. Resident may not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 6	F 282		

always walk full distance, do what she can.

R6's ambulation tracking sheets for the time period 10/31/16-11/6/16, included only an "X" on two of the seven days (11/5 and 11/6/16), with no distance recorded. The "X" indicated that R6 had walked.

R6's quarterly MDS dated 8/3/16, indicated R6 had a BIMS score of 13 (cognitively intact) and required extensive assistance of one staff for locomotion.

R6's CAA for activities of daily living (ADLs)/functional rehabilitation potential dated 2/29/16, indicated R6 was at risk for decline due to weakness, intermittent pain and history of falls; Proceed to care plan to improve abilities related to ADLs.

During interview on 11/7/16, at 2:00 p.m. nursing assistant (NA)-A stated R6 had an exercise program and showed survey staff a binder including the ambulation tracking sheets for 10/31/16 -11/6/16 which indicated R6 had been walked to and from meals on 11/6/16. NA-F was also present and indicated she sometimes had a difficult time getting R6 to ambulate to the meals; stating R6 would "find a reason" not to walk.

During interview on 11/8/16, R6 stated she did not walk today and did not walk all day on 11/7/16. R6 did not indicate she had refused ambulation.

Review of R6's nursing progress notes for the time period of 10/31/16-11/9/16 did not reveal she had refused ambulation.

R15's quarterly MDS, dated 9/21/16 identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 7	F 282		

R15 required supervision and assist of one for transfers, and ambulated in room and corridor only once or twice during look back period with no set-up or physical help from staff. The MDS identified a BIMS score of 15 (cognitively intact).

R15's CAA for activities of daily living (ADL) dated 4/12/16, identified triggers due to needing assistance with his cares, and balance issues during transitions. R15's care plan revised 10/4/16, indicated R15 ambulated independently to needing supervision of one with a walker and used a wheelchair for longer distances independently.

R15 was listed on the daily walking list. The daily walking list instructed caregivers to ambulate R15 to/from meals following with wheelchair or in hallway. R15's daily walking list, from the previous 30-day period did not include any documented walks.

When interviewed on 11/7/16, at 12:42 p.m. R15 stated he transfers self from his recliner chair to his wheelchair but further indicated he uses his wheelchair for locomotion.

On 11/8/16, at 11:48 a.m. R15 was observed propelling self down hallway in his wheelchair to dining room for lunch.

During interview on 11/9/16, at 11:43 a.m. NA-G stated R15 ambulates with a walker and one assist on the evening shift.

During interview on 11/9/16, at 12:22 p.m. RN-B stated R15's family walks with him almost daily when they visit. RN-B indicated R15 used a walker and was followed by wheelchair with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

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F 282	Continued From page 8	F 282		

family. RN-B further stated R15 was not on a nursing ambulation program.

R8's face sheet located in the medical record dated 11/9/16, identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and osteoarthrosis.

R8's most current quarterly MDS dated 8/11/16, identified R8 required limited assistance of one staff person for transfers and walking in the corridor. The MDS also identified a BIMS score of 13 (cognitively intact).

R8's CAA related to ADL's dated 3/8/16, identified R8 triggered due to needing assistance with his activities of daily living, and having balance issues during transitions. Additional risk factors for decline in ADL's include a spinal cord injury with arm weakness, use of a walker and a wheelchair for locomotion; Proceed to care plan to avoid complications.

R8's care plan last revised on 10/08/16 indicted R8 had limited physical mobility related to weakness, and was to walk around the square three to four times a day.

R8's nursing progress notes for the months of 10/16 and 11/16 indicated R8 walked on 11/1/16 three times this evening with one staff assisting. On 10/28/16, R8 was documented to have walked once in the hallway at 8:10 p.m., no distance was charted. On 10/24/16, R8 was documented to ambulate twice that evening, with one assist. No distance was documented. On 10/23/16, R9 was documented to have charted twice that evening with one assist. On 10/19/16,

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 _____	11/09/2016

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

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F 282	Continued From page 9	F 282		

R8 was documented to have ambulated twice with the nursing assistant in the hallways. No distance was charted.

During observation on 11/8/16, at 1:03 p.m. R8 was observed seated in his wheelchair, playing cards with a visitor.

During a continuous observation on 11/8/16, from 3:49 p.m. until 5:56 p.m., R8 was seated in the lobby playing dice games with other residents. R8 was not observed to be approached about talking a walk.

During interview on 11/8/16, at 4:47 p.m. NA-A indicated R8 should walk three to four times per day. NA-A stated the information should be charted on a sheet kept at the nursing station, which was blank for the current date as of this time (4:50 p.m.).

During interview on 11/8/16, at 4:59 p.m. NA-C and NA-B indicated R8 should walk three to four times per day, which was documented on a walking list and transferred into the computer by RN-B at some point during the month.

During interview on 11/8/16, at 5:04 p.m. R8 stated he had not walked all day today.

During interview on 11/9/16, at 7:45 a.m. NA-D confirmed R8 should walk several times per day.

During interview on 11/9/16, at 8:35 a.m., RN-B indicated R8 should be walking several times per day, and the results should be recorded on the walking sheets. RN-B provided the previous month's ambulation flow sheets at this time. However, it only included ten days of sheets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

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F 282	Continued From page 10	F 282		

which had been submitted. Of the ten days of walking sheets provided, R8 only walked 15 of 30 opportunities, or an average of once or twice daily. The walking sheets indicated R8 was to ambulate four times daily with a wheeled walker 200 feet with assistance of one staff.

During further interview on 11/9/16, at 11:15 a.m. the DON indicated the walks were not put into the computer system, although sometimes they might be documented in the nursing progress notes, stating there currently was not really a good way of documenting ambulation. The DON confirmed it was expected staff would ambulate residents in accordance with the care plan.

The facility policy, entitled Rehabilitative and Restorative Program, dated 11/8/16 indicated nursing care is directed toward conservation of abilities of residents, restoration of optimal levels of function and independence, adaptation to an altered life style, and prevention of deterioration, and complications of disability.

Repositioning:
R8's care area assessment (CAA) for pressure ulcers dated 3/8/16 identified R8 had risk factors for pressure ulcers and required a special seat cushion to reduce or relieve pressure, was immobile and incontinent, had altered mental state, and had a history of PU; Proceed to care plan to avoid complications.

R8's care plan dated 11/7/16 indicated R8 was at risk for PU related to needing extensive assistance with bed mobility, frequent urinary incontinence, assistance with ADL's and weakness. The care plan identified R8 was to be encouraged to off load every 15-20 minutes to the

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	245274	A. BUILDING _____ B. WING _____	11/09/2016

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**

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F 282	Continued From page 11	F 282		

left side when possible through out the day while awake for pressure reduction.

R8's face sheet, dated 11/9/16 identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and urinary incontinence.

During interview on 11/6/16, at 2:02 p.m. registered nurse (RN)-A indicated R8 had a Stage II PU on his right buttock that had been present since 3/10/16, and was recurrent.

During observation and interview on 11/7/16, at 12:46 p.m. R8 stated he had a "pimple area" on his bottom. R8 stated the staff repositioned him once or twice a day, and he could transfer himself in and out of the wheelchair to go to the bathroom.

During observation on 11/8/16, at 1:03 p.m. R8 was seated in his wheelchair, playing cards in the lobby.

During continuous observations on 11/8/16, from 3:49 to 5:56 p.m., R8 was noted to be seated in his wheelchair and was not observed to make significant changes in his position independently. No staff were observed to remind R8 to shift his weight (no offload).

During interview on 11/8/16, at 5:56 p.m., R8 stated he stood up on his own about three or four times daily when he took himself to the bathroom and did not otherwise receive repositioning or reminders to shift his weight from staff.

During interview on 11/8/16, at 4:47 p.m. nursing

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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 282	Continued From page 12 assistant (NA)-A indicated R8 walked three or four times during the day and was independent with transfers in his room. R8 did not receive routine repositioning from staff. During interview on 11/8/16, at 4:49 p.m. NA-B and NA-C indicated they were not aware of any skin concerns for R8. Both stated R8 repositioned himself during the day, was not reminded to reposition himself. During interview on 11/09/16, at 7:45 a.m. NA-A and NA-D stated R8 did not have any specific repositioning program while in the wheelchair. During observation on 11/9/16, at 12:25 p.m. R8's buttock ulcer was observed with RN-A, who confirmed the area was a Stage II PU, with an observed total area of 4 cm by 5 cm of redness with an open slit in the center which was noted shiny red tissue to the wound base, measuring 0.8 cm by 1 cm. During interview on 11/9/16, at 11:17 a.m. the DON indicated she thought R8 usually moved himself around enough in his chair and that staff were not encouraging him to reposition. The facility policy, entitled Integumentary System: Skin Integrity, dated 11/9/16 indicated patients will be assessed for risk of developing a skin alteration. Nursing will develop an individualized, interdisciplinary plan of care for prevention of altered skin integrity on hospitalized patients.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		12/8/16

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 _____	11/09/2016

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

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F 309	Continued From page 13 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 monitor bruising/bleeding for 1 of 3 residents (R15) reviewed for non-pressure related skin conditions. Findings include: Review of R15's diagnosis report included diagnosis of thrombocytopenia (deficiency of platelets in the blood that causes bleeding into the tissues, bruising, and slow blood clotting after injury). On 11/6/16, at 2:22 p.m. R15 was observed to have two dime sized dark purple bruises with lighter purple bruising around the area approximately 3 centimeters (cm) in diameter. During interview with resident at this time, he stated he obtained the bruises when going through door ways, reaching and bumping right hand. On 11/9/16, at 11:38 a.m. R15 stated, "I bruise easy". Review of R15's physician orders dated 9/27/16 included an order for prednisone (a medication used to suppress the immune system with a side effect of increased bruising tendency) 10 milligrams (mg) by mouth in the morning for low platelets (component of the blood that help the blood clot) and an order on 10/17/16 to decrease	F 309	Resident□s bruises have been documented on skin assessment form and care plan has been updated. Nurses were instructed on use of Nursing Checklist for Skin alterations. Audits will be completed every week times 2; every other week times 2; monthly times 2; and quarterly times 2 to ensure compliance with documentation of skin alterations and updating the resident□s care plan. Done by DON or designee. Results of audits will be presented to the QA committee.	

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 _____	11/09/2016

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

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F 309	Continued From page 14 prednisone to 7.5 mg daily. Review of R15's laboratory results from 9/6/16 to 10/31/16 indicate weekly platelet levels were drawn. R15's platelet results ranged from 22,000-32,000 per liter (L) with a normal reference range of 150,000-450,000 platelets per L. The progress note indicated a call from the laboratory indicating R15 had a critically low platelet count of 26,000 per L on 10/17/16. Review of R15's care plan, revised 10/4/16, identified R15 as being at risk for pressure ulcers with risk factors including previous pressure ulcers, diagnosis, medications, use of a wheelchair (w/c) for primary mode of locomotion, and history of skin irritation. The care plan did not include R15 as being at risk for bleeding/bruising, no reference to the diagnosis of thrombocytopenia nor include any interventions related to bleeding/bruising. During interview on 11/8/16, at 12:34 p.m. licensed practical nurse (LPN)-B stated on bath days new skin concerns would be noted and documented with measurements on skin sheet, and that it is also put into the medication administration record (MAR) to monitor daily until healed. A progress note is documented. LPN-B stated a bruise was identified on R15's right hand with bath today but had not completed a wound documentation sheet yet. During interview on 11/9/16, at 7:33 a.m. registered nurse (RN)-B indicated R15 has had diagnosis of thrombocytopenia for over a year and was being treated with prednisone, and further stated R15 had been having critical low platelet levels. RN-B verified no care plan nor	F 309		

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 _____	11/09/2016

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 309	Continued From page 15 interventions were identified related to R15's risk for bleeding/bruising, stating "that should've been in there". During interview on 11/9/16, at 12:50 p.m. director of nursing (DON) indicated all non-pressure skin problems were to be documented on a wound documentation sheet which includes wound type, location, measurement, drainage, odor, and checking a box for updating care plan as needed. The DON stated her expectation was for it to be completed by licensed staff and that bruises would be documented weekly until resolved. The DON further stated the expectation was to have a care plan developed related to the clotting disorder so that staff could follow the identified plan. On 11/9/16, the facility provided copies of the 11/16 medication administration record (MAR) and treatment administration record (TAR). Review of the documents lacked any mention nor monitoring of the right hand bruise. In addition, review of R15's wound documentation dated 7/23/16 to 10/22/16, lacked any monitoring related to skin bruising. An undated facility form titled Nursing Checklist for Skin Alterations (i.e. Pressure Ulcers, Surgical, Vascular, Diabetic, Skin Tears, Bruises, Rashes) instructs to assess skin alteration and document the following: location, type of skin alteration, measurement, and add treatment to TAR for weekly measurement and documentation, develop, review and update care plan as interventions are added/changed/discontinued.	F 309		
F 311	483.25(a)(2) TREATMENT/SERVICES TO	F 311		12/8/16

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 _____	11/09/2016

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

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F 311 SS=E	Continued From page 16 IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities 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 services necessary to maintain ambulation ability for 4 of 4 residents (R28, R6, R15, R8) reviewed for activities of daily living (ADL). Findings include: R28 R28's quarterly Minimum Data Set (MDS) assessment dated 8/3/16, identified R28 required extensive assistance of two for transfers and limited assistance of two people for ambulation in the corridor. The MDS identified a diagnosis of non-Alzheimer's dementia. The MDS identified a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). R28's Care Area Assessment (CAA) related to ADL's dated 5/25/16, identified triggers due to needing assistance with cares, cognitive impairment and balance issues; proceed to care plan and continue to assist with ADL's. R28's care plan last revised 10/4/16, indicated R28 required assistance of one staff with walking and locomotion, using a walker and wheelchair. R28 was to be encouraged to walk to and from meals and activities.	F 311	All residents are assessed quarterly during the MDS process for any change in ADL function. CNAs are aware to notify charge nurse with any changes in residents' ADL function. All residents with ambulation programs will be audited as described. CNAs have been updated on resident's ambulation programs and taught proper documentation. Care plans have been updated. Documentation of ambulation programs will be updated in PointClickCare for easier documentation for CNAs Audits will be completed weekly times 2; every other week times 2; monthly times 2 and quarterly times 2 to monitor compliance with ambulation programs. Done by DON or designee. Results of audits will be presented to the QA committee.	

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 _____	11/09/2016

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 311	Continued From page 17	F 311		

R28's daily walking lists, from the previous 30-day period did not include any documented walks/ambulation.

R28's physical therapy (PT) discharge instructions dated 3/7/16, indicated R28 was to ambulate to and from the dining room with staff assistance.

During observation on 11/7/16, at 12:52 p.m. R28 wheeled himself from the dining room; R28 was not observed to be ambulated from the meal with staff assistance.

During interview on 11/7/16, at 12:55 p.m. R28 stated, "There's a few girls that walk me everyday. I need to walk more so I'm not sitting all the time."

During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for the noon meal and was not walked in accordance with the recommendation from the PT discharge orders.

During observation on 11/8/16, at 12:31 p.m. R28 was observed to wheel himself to and from the noon meal; no staff offered to assist him with ambulation.

During observation on 11/8/16, at 12:34 p.m. no walking program instructions or sheets were observed in R28's room.

During interview on 11/8/16, at 3:30 p.m. the director of nursing (DON) stated that "ambulation is a deficiency of ours," and the facility was attempting to work on improving this task. The DON stated there should be a form inside of the

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 _____	11/09/2016

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 311	Continued From page 18 resident's room to document exercise activity. The DON stated that walking to and from meals was during a busy time of day, and consequently another time of the day may work better. During follow up interview on 11/8/16, at 4:02 p.m. the DON confirmed there was not a walking sheet nor exercise sheet located in R28's room at this time. During observation of the breakfast meal on 11/9/16, at 8:21 a.m. R28 was observed to wheel himself to the dining room. R6 During observation of the breakfast meal on 11/7/16, at approximately 8:30 a.m. R6 was not observed to be ambulated to the morning meal. During observation of the noon meal on 11/7/16, at 1:04 p.m. R6 was wheeled back to the room by visitors and was not offered by staff to ambulate. R6's face sheet located in the medical record dated 11/8/16, identified diagnoses of osteoarthritis and an artificial right shoulder, as well as history of falls. R6's care plan last updated 10/31/16, indicated R6 was to be walked- starting 10/31/16 to/from meals and activities with a wheeled walker and assist of one to two staff. Resident may not always walk full distance, do what she can. R6's ambulation tracking sheets for the time period 10/31/16-11/6/16, included only an "X" on two of the seven days (11/5 and 11/6/16), with no distance recorded. The "X" indicated that R6 had walked.	F 311		

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 _____	11/09/2016

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 311	Continued From page 19	F 311		

R6's quarterly MDS dated 8/3/16, indicated R6 had a BIMS score of 13 (cognitively intact) and required extensive assistance of one staff for locomotion.

R6's CAA for activities of daily living (ADLs)/functional rehabilitation potential dated 2/29/16, indicated R6 was at risk for decline due to weakness, intermittent pain and history of falls; Proceed to care plan to improve abilities related to ADLs.

During interview on 11/7/16, at 2:00 p.m. nursing assistant (NA)-A stated R6 had an exercise program and showed survey staff a binder including the ambulation tracking sheets for 10/31/16 -11/6/16 which indicated R6 had been walked to and from meals on 11/6/16. NA-F was also present and indicated she sometimes had a difficult time getting R6 to ambulate to the meals; stating R6 would "find a reason" not to walk.

During interview on 11/8/16, R6 stated she did not walk today and did not walk all day on 11/7/16. R6 did not indicate she had refused ambulation.

Review of R6's nursing progress notes for the time period of 10/31/16-11/9/16 did not reveal she had refused ambulation.

R15

R15's quarterly MDS assessment dated 9/21/16, identified R15 required supervision and assist of one for transfers, and ambulated in room and corridor only once or twice during look back period with no set-up or physical help from staff. The MDS identified a BIMS score of 15 (cognitively intact).

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 _____	11/09/2016

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 311	Continued From page 20	F 311		

R15's CAA for activities of daily living (ADL) dated 4/12/16, identified triggers due to needing assistance with his cares, and balance issues during transitions. Additional risk factors included medication, history of falls, diagnosis, use of a walker and wheelchair for locomotion, occasional urinary incontinence and decreased hearing; Proceed to care plan to maintain current level of functioning.

R15's care plan revised 10/4/16, indicated R15 ambulated independently to needing supervision of one with a walker and used a wheelchair for longer distances independently.

R15 was listed on the daily walking list. The daily walking list instructed caregivers to ambulate R15 to/from meals following with wheelchair or in hallway. R15's daily walking list, from the previous 30-day period did not include any documented walks.

When interviewed on 11/7/16, at 12:42 p.m. R15 stated he transfers self from his recliner chair to his wheelchair but further indicated he uses his wheelchair for locomotion.

On 11/8/16, at 11:48 a.m. R15 was observed propelling self down hallway in his wheelchair to dining room for lunch.

During interview on 11/9/16, at 11:43 a.m. NA-G stated R15 ambulates with a walker and one assist on the evening shift.

During interview on 11/9/16, at 12:22 p.m. RN-B stated R15's family walks with him almost daily when they visit. RN-B indicated R15 used a walker and was followed by wheelchair with

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 _____	11/09/2016

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 311	Continued From page 21	F 311		

family. RN-B further stated R15 was not on a nursing ambulation program.

R8

R8's face sheet located in the medical record dated 11/9/16, identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and osteoarthrosis.

R8's most current quarterly MDS assessment dated 8/11/16, identified R8 required limited assistance of one staff person for transfers and walking in the corridor. The MDS also identified a BIMS score of 13 (cognitively intact).

R8's CAA related to ADL's dated 3/8/16, identified R8 triggered due to needing assistance with his activities of daily living, and having balance issues during transitions. Additional risk factors for decline in ADL's include a spinal cord injury with arm weakness, use of a walker and a wheelchair for locomotion; Proceed to care plan to avoid complications.

R8's care plan last revised on 10/08/16 indicted R8 had limited physical mobility related to weakness, and was to walk around the square three to four times a day.

R8's nursing progress notes for the months of 10/16 and 11/16 indicated R8 walked on 11/1/16 three times this evening with one staff assisting. On 10/28/16, R8 was documented to have walked once in the hallway at 8:10 p.m., no distance was charted. On 10/24/16, R8 was documented to ambulate twice that evening, with one assist. No distance was documented. On 10/23/16, R9 was documented to have charted twice that evening with one assist. On 10/19/16,

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 _____	11/09/2016

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 311	Continued From page 22	F 311		

R8 was documented to have ambulated twice with the nursing assistant in the hallways. No distance was charted.

During observation on 11/8/16, at 1:03 p.m. R8 was observed seated in his wheelchair, playing cards with a visitor.

During a continuous observation on 11/8/16, from 3:49 p.m. until 5:56 p.m., R8 was seated in the lobby playing dice games with other residents. R8 was not observed to be approached about talking a walk.

During interview on 11/8/16, at 4:47 p.m. NA-A indicated R8 should walk three to four times per day. NA-A stated the information should be charted on a sheet kept at the nursing station, which was blank for the current date as of this time (4:50 p.m.).

During interview on 11/8/16, at 4:59 p.m. NA-C and NA-B indicated R8 should walk three to four times per day, which was documented on a walking list and transferred into the computer by RN-B at some point during the month.

During interview on 11/8/16, at 5:04 p.m. R8 stated he had not walked all day today.

During interview on 11/9/16, at 7:45 a.m. NA-D confirmed R8 should walk several times per day.

During interview on 11/9/16, at 8:35 a.m., RN-B indicated R8 should be walking several times per day, and the results should be recorded on the walking sheets. RN-B provided the previous month's ambulation flow sheets at this time. However, it only included ten days of sheets

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 _____	11/09/2016

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 311	Continued From page 23 which had been submitted. Of the ten days of walking sheets provided, R8 only walked 15 of 30 opportunities, or an average of once or twice daily. The walking sheets indicated R8 was to ambulate four times daily with a wheeled walker 200 feet with assistance of one staff. During further interview on 11/9/16, at 11:15 a.m. the DON indicated the walks were not put into the computer system, although sometimes they might be documented in the nursing progress notes, stating there currently was not really a good way of documenting ambulation at this point in time. The DON confirmed it was expected staff would ambulate residents in accordance with the care plan. The facility policy, entitled Rehabilitative and Restorative Program, dated 11/8/16 indicated nursing care is directed toward conservation of abilities of residents, restoration of optimal levels of function and independence, adaptation to an altered life style, and prevention of deterioration, and complications of disability.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		12/8/16

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 _____	11/09/2016

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 314	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services to promote healing of a pressure ulcer (PU) for 1 of 1 resident (R8) reviewed who experienced a recurrent stage II pressure ulcer (defined as a partial-thickness loss of skin with exposed dermis, with a wound bed that is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister). Findings include: R8's most current quarterly Minimum Data Set (MDS) assessment dated 8/11/16, identified R8 had two stage II pressure ulcers. The MDS also identified a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). R8's care area assessment (CAA) for pressure ulcers dated 3/8/16 identified R8 had risk factors for pressure ulcers and required a special seat cushion to reduce or relieve pressure, was immobile and incontinent, had altered mental state, and had a history of PU; proceed to care plan to avoid complications. R8's care plan dated 11/7/16, indicated R8 was at risk for pressure ulcers related to needing extensive assistance with bed mobility, frequent urinary incontinence, assistance with activities of daily living and weakness. The care plan identified R8 had a pressure ulcer on the right buttocks. Interventions included: assessing, monitoring and measurement of the wounds, treatments as ordered and encouraging R8 to off load [reduce pressure] every 15-20 minutes to the left side when possible throughout the day while awake for pressure reduction and use of	F 314	The Braden scale is completed upon admission, significant change and quarterly for all residents. This will be used to assess residents that are at risk for developing pressure ulcers. Interventions for prevention of pressure ulcers will be initiated as indicated from the Braden scale score.Resident□s care plan has been updated for staff to remind him to reposition self in w/c. Staff are aware of need to remind resident to reposition himself throughout the day while in w/c. A new w/c cushion per physical therapy was provided for resident. Pressure Ulcer Policy was reviewed with nurses to reiterate proper protocol for residents that have pressure ulcers or are at risk for pressure ulcers. Audits will be completed every week times 2; every other week times 2; monthly times 2 and quarterly times 2 to monitor compliance with the Pressure Ulcer Policy. Done by DON or designee. Results of audits will be presented to the QA committee.	

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 _____	11/09/2016

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

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F 314	Continued From page 25 wheelchair cushions. R8's face sheet, dated 11/9/16 identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and urinary incontinence. R8's most current Braden scale score (an assessment tool used to identify risk for development of pressure ulcers) dated 10/28/16, indicated a total scoring of 24 (maximum number of points should have be 23, friction risk score was indicated as a 4 out of a possible of only 3 points) which indicated R8 was not at risk for pressure ulcer development. R8's wound documentation flow sheets for the time period of 3/10/16 through 11/6/16, indicated R8 initially started with a 2 centimeter (cm) by 2.6 cm hardened, red area on the right buttocks which intermittently healed over and re-opened with the most recent measurements documented on 10/23/16, indicated a wound bed which was 60% eschar (brown or black, non-viable tissue), 20% granulation (new connective tissue, usually of a darker red color that forms on the surface of a wound bed during healing) and 20% epithelial tissue (light pink colored tissue which forms during the wound healing process), which was measured 1.2 centimeters (cm) in size by 1.0 cm. A physical therapy (PT) progress note, dated 7/19/16 indicated R8 had a small, superficial laceration to the right upper buttock and would benefit from unweighting this area intermittently during the day, as well as to keep the area clean and covered. The PT progress note did not include any assessment of the wheelchair cushion/support surface.	F 314		

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 _____	11/09/2016

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

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F 314	Continued From page 26	F 314		

During interview on 11/6/16, at 2:02 p.m. registered nurse (RN)-A indicated R8 had a stage II PU located on the right buttock that had been present since 3/10/16, which was recurrent.

During observation and interview on 11/7/16, at 12:46 p.m. R8 stated he had a "pimple area" on his bottom. R8 stated the staff repositioned him once or twice a day, and he could transfer himself in and out of the wheelchair to go to the bathroom. R8 stated he had a cushion in his wheelchair. R8 was seated on a blue colored, vinyl style seat cushion. R8 stated he did experience some discomfort on his buttock to the wound area while lying in bed at night. However, R8 indicated he did not have pain in the wound located on his buttock while seated in the wheelchair.

During observation with the surveyor on 11/7/16, at 1:02 p.m. licensed practical nurse (LPN)-A observed R8's PU. R8 wheeled himself into his bathroom, was able to stand up, hold onto the grab bar next to the toilet and to remain standing for his wound care. LPN-A donned gloves and removed a foam dressing from R8's buttocks, cleansed R8's buttocks with normal saline and patted dry. LPN-A removed her gloves, cleansed her hands and indicated R8 had a stage II pressure ulcer located on the right buttock. LPN-A reported it did not contain eschar. The area was observed to be primarily reddened with a very small slit in the center with non-adherent, flaking skin. LPN-A measured the entire area with redness as 4 cm x 5 cm. After measuring the wound, LPN-A applied a clean foam dressing to the ulcer. LPN-A indicated R8 had the current wheelchair cushion for quite awhile and was unsure whether a different cushion had been

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 _____	11/09/2016

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 314	Continued From page 27 tried/reassessed since development of the PU. During observation on 11/8/16, at 1:03 p.m. R8 was seated in his wheelchair, playing cards in the lobby. R8 demonstrated no verbal/non-verbal signs of discomfort. During continuous observations on 11/8/16, from 3:49 to 5:56 p.m., R8 was noted to be seated in his wheelchair and was not observed to make significant changes in his position independently. No staff were observed to remind R8 to shift his weight during the observed timeframe. During interview on 11/8/16, at 5:56 p.m., R8 stated he stood up on his own about three or four times daily when he took himself to the bathroom and did not otherwise receive repositioning nor reminders from staff to shift his weight while seated. R8 indicated his wheelchair cushion had never been evaluated and/or changed after development of the buttock PU; however, stated "they sure could!" During interview on 11/8/16, at 4:47 p.m. nursing assistant (NA)-A indicated R8 walked three or four times during the day and was independent with transfers in his room. R8 did not receive routine repositioning from staff. During interview on 11/8/16, at 4:49 p.m. NA-B and NA-C indicated they were unaware of any skin concerns for R8. Both stated R8 repositioned himself during the day, was not reminded to reposition himself and that staff were to walk him several times per day. During interview on 11/09/16, at 7:45 a.m. NA-A indicated R8 should walk several times per day	F 314		

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 _____	11/09/2016

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 314	Continued From page 28	F 314		

and was aware R8 did have a wound on his bottom. NA-D was present also at this time and stated R8 did not have any specific repositioning program while in the wheelchair.

When interviewed on 11/9/16, at 8:35 a.m. RN-B (MDS Coordinator) indicated R8 was to walk several times per day. RN-B stated R8 had been provided with a new wheelchair due to the concern he was causing trauma to his ankles, bumping them into the wheels. RN-B confirmed she was unaware of any seat cushion changes since the development of R8's buttock ulcer.

During observation on 11/9/16, at 12:25 p.m. R8's buttock ulcer was observed with RN-A, who confirmed: the area was a stage II PU, the total area of 4 cm x 5 cm of redness had an open slit in the center with shiny red tissue extending to the wound base, which measured 0.8 cm by 1 cm.

When interviewed on 11/9/16, at 11:17 a.m. the director of nursing (DON) indicated she thought R8 usually moved himself around enough in his chair and so staff were not encouraging him to reposition. The DON indicated they had not reassessed R8's ability to reposition himself adequately in the wheelchair since the PU developed. The DON thought the area was not in a location [on the buttock] R8 sat on, while in the wheelchair and was unaware of any recent changes in his wheelchair cushions.

The facility policy, entitled Pressure Ulcer Management, dated 11/9/16 indicated pressure ulcers were assessed on admission, at initiation of treatment, with each dressing change or care intervention, upon transfer, and prior to

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 _____	11/09/2016

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 314	Continued From page 29 discharge. The facility policy, entitled Integumentary System: Skin Integrity, dated 11/9/16 indicated patients will be assessed for risk of developing a skin alteration. Nursing will develop an individualized, interdisciplinary plan of care for prevention of altered skin integrity on hospitalized patients. The policy did not address other preventive measures for pressure ulcers beyond skin assessments and weekly wound documentation.	F 314		
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.	F 329		12/8/16

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 _____	11/09/2016

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

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F 329	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to evaluate the effectiveness and identify parameters for the use of as needed (PRN) pain medications (acetaminophen and Tramadol) for 1 of 5 residents (R23) reviewed for unnecessary medications. In addition, based on observation, interview and document review the facility failed to evaluate the effectiveness of PRN pain medications for 1 of 1 resident (R53) reviewed with pain. Findings include: R23 was admitted on 6/9/16, with diagnoses of chronic pain syndrome and history of left hip fracture per care plan. R23's signed physician orders dated 9/12/16, included orders for acetaminophen tablet 500 milligrams (mg) 2 tablets by mouth every 6 hours PRN pain or fever and Tramadol 50 mg by mouth every six hours PRN pain control. The quarterly Minimum Data Set (MDS) assessment dated 9/7/16, identified R23 as having a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition, and receiving PRN and non-medication interventions for pain. Pain assessment interview in the MDS further identifies R23 as having frequent pain rating it a 7 on 1-10 pain scale. Review of R23's care plan dated 9/15/16 included a goal indicating R23 would verbalize adequate relief of pain and instructed licensed and	F 329	Parameter orders were received for the two pain medications that resident 53 uses. Resident 53 has been discharged from the facility. All residents will be assessed for pain medication parameters with 30 day drug reviews by the consulting pharmacist. Resident□s pain medications have been updated to include parameters for use. Pain Management Policy was reviewed with nurses. PRN medications must include follow-up charting to determine effectiveness of medication. Pain level parameters will be asked for with pain medication orders. Audits will be completed every week times2, every other week times 2, monthly times 2 and quarterly times 2 to monitor compliance with prn medication follow up and use of parameters with medication orders. Done by DON or designee. Results of audits will be presented to the QA committee.	

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 _____	11/09/2016

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 329	Continued From page 31	F 329		

unlicensed nursing staff to monitor/document for side effects of pain medication, monitor /record pain characteristics PRN, Monitor/record/report to nurse any signs or symptoms of non-verbal pain, monitor/record/report to nurse loss of appetite, refusal to eat and weight loss.

Review of R23's medication administration record (MAR) for October and November 2016 identified the following:

- R23's MAR dated 10/16, identified R23 received 9 doses of PRN acetaminophen and 14 doses of PRN Tramadol during the month for discomfort. R23's Nurse's medication notes (tool used to monitor PRN medication effectiveness of administered medication) dated 8/30/16 to 11/7/16 identified spacing to record the date and time of PRN administration, medication, strength, dose, reason for administration provided and result from PRN medication given, time, and initials. However, there was no result/follow up documented on form to determine if the provided medication had been effective.

-R23's MAR dated 11/16, identified R23 received 4 doses of PRN acetaminophen and 3 doses of PRN Tramadol for discomfort. No result/follow up documented on form to determine if the provided medications had been effective.

Review of nursing progress notes dated 10/1/16 through 11/7/16 supported only three entries that identified no further complaints of pain after PRN administration of Tramadol 10/15/16, acetaminophen on 10/18/16, and Tramadol on 11/2/16.

During interview on 11/8/16, at 11:40 a.m. trained

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 _____	11/09/2016

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 329	Continued From page 32	F 329		

medication aide (TMA)-A stated if a resident requests a PRN medication, she notifies the charge nurse, and further stated PRN medications were not given by TMA's unless directed by the charge nurse on what medication to administer. At 11:42 a.m. registered nurse (RN)-C stated "its a nursing judgment call"; if the pain is rated less than 5 (pain scale 1-10) Tylenol is given and higher than 5 give the stronger medication. RN-C further indicated PRN's were to be documented on medication note form and assessed for effectiveness.

During interview on 11/8/16 at 4:34 p.m. RN-C verified PRN medications were not consistently documented nor re-evaluated for effectiveness on the medication note form nor in nursing progress notes. RN-C also confirmed there were no parameters identified related to administration of acetaminophen vs. Tramadol.

During interview on 11/9/16, at 9:51 a.m. RN-A indicated it is a nursing judgement on which PRN pain medication to administer and further indicated there was no pain rating number across the board unless specifically ordered by the physician.

During interview on 11/9/16, at 12:48 p.m. director of nursing (DON) confirmed there is no consistent adminsitration of PRN pain medications without parameters for acetaminophen and Tramadol, and verified the lack of monitoring documentation for effectiveness once a PRN had been given. The DON stated her expectation was that more of the medical doctors would write the orders with a parameter, however, not all of them were doing it and staff had not been informed of this expectation yet.

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 _____	11/09/2016

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 329	Continued From page 33	F 329		

During interview on 11/9/16, at 1:24 p.m. consultant pharmacist indicated she would expect pain medications to be clarified with a parameter and expect staff to review effectiveness of pain medications after given them.

R53's face sheet, dated 11/8/16 identified current diagnoses of end stage renal disease and a fracture of the left femoral neck and an admission date of 10/31/16.

R53's Minimum Data Set (MDS) assessment and Care Area Assessments (CAA) were in progress and not fully completed for for review.

R53's pain assessment, undated and unsigned, indicated R53 had left hip surgical incision pain which was sharp in intensity. Tylenol, Vicodin and oxycodone were listed as medications used, with the most effective listed as oxycodone.

R53's clinic referral form dated 11/3/16, indicated to administer Flexeril for muscle spasm and continue to work with physical therapy (PT).

R53's physician's orders dated 11/1/16, indicated orders for oxycodone (a short acting narcotic pain medication) 5 milligrams (mg) every four hours as needed (PRN).

R53's physician's orders dated 11/3/16, indicated orders for Flexeril (a muscle relaxant) 5 mg three times daily for seven days PRN for muscle spasm.

R53's clinic referral dated 11/3/16 - Flexeril for muscle spasms, continue to work with PT, encourage to get tup and walk often. Order for

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 _____	11/09/2016

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 329	Continued From page 34	F 329		

Flexeril 5 mg po for 7 days PRN for muscle spasms.

R53's medication sheets dated 11/16, indicated R53 had taken the Flexeril a total of ten times since it was ordered on 11/3/16, and had been receiving the oxycodone 5 mg on 28 occasions, on average four times/day since the order was received.

The Lutz Wing Pain Progress notes, dated 11/16 which included documentation for pain levels with the as needed (PRN) pain medications only included documentation of the reason for the pain medication and/or a pain rating recorded on 12 occasions. Pain levels were listed ranging from 5- 7 (10 point rating scale). No follow up response or assessment of the pain level after the medication was administered was documented.

During observation and on 11/7/16, at 12:29 p.m. R53 was seated in his room and indicated he had pain at a level of 5 (10 point scale) in his left leg, which was better than yesterday. However, R53 wished his pain level could be a zero and stated he last received oxycodone at 6:00 a.m. that morning. No non-verbal signs of pain were visualized at this time.

During observation and interview on 11/8/16, at 12:30 p.m. R53 was seated on the side of his bed, eating lunch. R53 stated his pain was very bad right now, rating it 15. R53 was observed with facial grimacing and stated he had a "cramp" in his thigh and had just received oxycodone for pain. R53 also stated he had taken Flexeril for his muscle spasm as well. R53 stated the nurses are "right here," ever 4 hours to offer pain medication. R4 was noted to an ice pack applied

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 _____	11/09/2016

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 329	Continued From page 35 on the left thigh at this time. During interview on 11/6/16, at 6:50 p.m. R53 stated he had just had a left hip replacement and was having pain in his left leg, which he rated a 7 (10 point scale). During interview on 11/7/16, at 1:36 p.m. registered nurse (RN)-D stated R53 was not always accepting of pain medications and had been somewhat depressed lately. RN-D stated staff asked him about his pain level with each medication pass and the trained medication assistants (TMA) staff should be doing so also. During interview on 11/8/16, at 12:41 p.m. RN-E indicated R53's fluid balance had been stable during dialysis and she had not noticed a significant degree of pain during his dialysis treatments, stating R53 appeared "fairly comfortable." RN-E felt most of R53's pain was due to his recent orthopedic surgery. During interview on 11/8/16, at 1:09 p.m. licensed practical nurse (LPN)-B stated she monitored R53's pain level with medication passes and that R53 had tried hot and cold packs today for the left hip. LPN-B indicated nursing staff were trying to offer R53 the Flexeril 3 times/day on a more scheduled basis to see whether this helped his pain, which had increased the last couple of days. During interview on 11/8/16, at 3:25 p.m. the DON it was verified that staff should not only be charting pain levels when they give the pain medication, but also the follow up response to the pain medications on the PRN medication flow sheets so that staff could evaluate the effectiveness.	F 329		

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 _____	11/09/2016

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 329	Continued From page 36 During interview on 11/9/16, at 1:22 p.m. the consultant pharmacist (CP) indicated staff should be evaluating effectiveness of pain medications an hour or so after giving them, to monitor for effectiveness and this should be documented. The facility policy, entitled Pain Management, dated 7/2/14 indicated the patient's self-report is accepted as the most accurate measure of the current level of pain. A zero to ten numeric pain intensity scale was listed as an acceptable tool. For long term care settings, the policy indicated reassessment should occur after pain interventions, with a change in condition, a new report of pain, exacerbation of pain and at discharge or transfer to another level of care. The policy further stated this should be done in a timely manner according to the expected outcomes for the intervention (e.g. efficacy of an opioid).	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334		12/8/16

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 _____	11/09/2016

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F 334	Continued From page 37 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334		

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F 334	Continued From page 38 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement their policy and procedure related to the pneumococcal conjugate vaccine (PCV13) according to recommendations by the Centers for Disease Control (CDC) for 9 of 23 residents (R5, R7, R15, R19, R23, R25, R29, R30 and R34) whose vaccination histories were received and who had been seen by a medical practioner following distribution of the memo/plan dated 09/22/16. Findings include: R5's vaccination record indicated an admission date of 5/20/13, and received the Pneumovax (23 Valent) on 5/10/12 per the MICC (Minnesota Immunization information Connection) system. R5 was seen by the medical practioner on 10/18/16 and there was no indication her vaccination status had been reviewed nor the PVC13 vaccination offered. R7's vaccination record indicated an admission date of 10/4/16, and received the 23 Valent on 10/1/07 per MICC system. R7 was seen by the medical practioner on 10/4/16, yet there was no	F 334	Residents have received pneumovax as needed per CDC recommendations. CDC recommendations for pneumovax have been reviewed with nurses. Nurses will check residents immunization records upon admission and ask providers for orders for immunizations that are deemed necessary. Audits will be completed after each admission for 3 months to ensure that the immunizations have been completed per CDC recommendation. Done by DON or designee. Results of audits will be presented to the QA committee.	

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F 334	Continued From page 39	F 334		

indication the vaccination status had been reviewed nor the PVC13 vaccination offered.

R15's vaccination record indicated an admission date of 5/7/12 and receipt of the 23 Valent on 3/31/09. R15 saw the medical practioner on 9/27/16; documentation was lacking to indicate the PVC13 vaccination had been offered.

R19 's vaccination record indicated an admission date of 4/8/11 and received the 23 Valent on 1/1/03. Although R19 was seen by the medical practioner on 10/4/16, and there was no documentation to indicate the PVC13 was offered.

R23's vaccination record indicated R23 had an admission date of 6/9/16 and received the 23 Valent on 1/1/00. R23 saw the medical practioner on 10/17/16, however, no PVC13 was not offered.

R25's vaccination record indicated an admission date of 1/7/16 and the most recent medical practioner visit was dated 10/4/16; there was no indication the PVC13 was offered.

R29's vaccination record indicated an admission date of 6/20/14 with receipt of the 23-Valent on 6/9/14. The most recent medical practioner visit on 9/22/16 with no indication the PVC13 was offered.

R30's vaccination record indicated an admission date of 6/27/14 with receipt of the 23-Valent on 12/15/99. The most recent medical practioner visit was dated 9/30/16, however documentation was lacking indicating the PVC13 was offered.

R34's vaccination record indicated an admission

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	245274	A. BUILDING _____ B. WING _____	11/09/2016

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F 334	Continued From page 40	F 334		

date of 8/24/15 with the 23-Valent administered on 10/16/06. R34 was most recently seen by the medical practitioner on 9/27/16; documentation was lacking to indicate the PVC13 had been offered.

The CDC recommendations indicated, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose."

Document review indicated an email dated 9/19/16, was sent to the nursing staff with the link to the Minnesota web site regarding administration recommendations for the PVC13 vaccination. In addition, an email dated 9/22/16, was sent to both the nursing and medical staff detailing the process for review of vaccination records and offering the PVC13 vaccination at the time of the next medical provider visit.

During interview on 11/8/16, at 12:16 p.m. the director of nursing (DON) indicated the charge nurse was supposed to be checking with the medical practioner (MD/NP) during rounds to determine the need for pneumococcal vaccination and to acquire the necessary orders. It was further indicated the process was set forth in a memo sent to the medical director dated 9/19/16 and follow-up email to nursing staff on 9/22/16. The DON confirmed she expected this memo to be implemented in a timely manner and verified the process had not been followed as planned.

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F 334	Continued From page 41 On 11/08/16, at 12:25 p.m. registered nurse (RN)-C was interviewed and indicated he was not aware of the email memo related to the implementation of the PVD process. However, licensed practical nurse (LPN)-B and RN-B who were also in attendance at this time, indicated they were aware of the memo dated 9/22/16 detailing the process. The health information coordinator (HIC) was interviewed on 11/08/16, at 12:35 p.m. and indicated the memo dated 9/22/16, detailed the process in which residents would be evaluated/updated with the current CDC recommendations during either a clinic and/or nursing home visit. It was confirmed there had been no process in place to implement/monitor whether this had been initiated.	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure pureed foods were held or served at the proper temperature to prevent foodborne illness for 4 of 4 residents	F 371	Education has been provided to staff to clarify that we must temp food just prior to serving in order to ensure correct temperature has been held. If necessary,	12/8/16

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F 371	Continued From page 42 (R16, R11, R19, R33) who had mechanically altered diets. Findings include: During observation of lunch meal on 11/8/16, at 11:54 a.m. dietary aide (DA)-A used a food thermometer to check the temperatures of the food in the steam table she was preparing to serve in the dining room. Food temperatures were recorded on the Daily Service log and DA-A began serving food onto trays. To the left side of the steam table area was a tray with four covered bowls of pureed chicken and biscuits. DA-A reported pureed food temperatures are not checked in the dining room because it is done in the kitchen and the pureed meals are kept in covered bowls on a tray located to side of steam table until served. DA-A further stated pureed meals are the last to be served during dish up. At 12:08 p.m. DA-A was ready to serve the bowls of pureed food when the surveyor requested a temperature check of the pureed chicken and biscuit. Upon completion, DA-A revealed a serving temperature of 110 and 111 degrees Fahrenheit (F) within the four bowls. DA-A explained that a serving temperature of 140 degrees F was desired, but since it was cooked already it was warm enough to serve, and proceeded to have the meals delivered. During interview on 11/8/16, at 3:23 p.m. the dietary manager (DM) stated after food is cooked to the temperature of 165 degrees F it is pureed, served into bowls, and delivered on a tray with other steam table food items. No holding nor serving temperature checks are routinely recorded once food has been pureed. At 4:01 p.m. the DM stated a safe serving temperature is	F 371	food will be reheated and placed in the steam table, or holding oven to maintain temperature prior to transport to NF. At NF, food will be placed in the appropriate holding area until the food is served, at which time the food will be temped again. A log of all temps will be kept in the NF for manager, or his designee, to audit and verify. This will be done once per week for the first month, 2x per month for the next two months and then quarterly for 2 quarters. Results of audits will be presented to the QA committee.	

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F 371	Continued From page 43 135 degrees (F) and confirmed that serving temperatures of pureed food at lunch today (11/8/16) were below that. The DM verified the facility needs to make changes in their process related to mechanically altered food so that a safe serving temperature was ensured, including documenting the pureed food temperatures. An Untitled form provided by facility, last revised 8/2009, indicated hot product holding temperatures must be maintained at 140 degrees F or above while holding and serving. It further recommended serving temperatures of meat, poultry, seafood, eggs at 145-165 degrees F to ensure hot at point of consumption.	F 371		
F 441 SS=D	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	F 441		12/8/16

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F 441	Continued From page 44 isolate the resident. (2) The facility must prohibit employees with a 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 proper hand hygiene had been performed during personal cares for 1 of 1 resident (R28) observed during morning cares. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 8/3/16, indicated required extensive assistance for dressing and toileting and limited assistance with personal hygiene of one staff member. The MDS also identified R28 was frequently incontinent of urine. During observation on 11/09/16, at 7:05 a.m. nursing assistant (NA)-E was observed completing morning cares for R28. NA-E was observed to don gloves, walk R28 to the bathroom, wash R28's back and underarms, then remove soiled bedding from R28's bed and lay it	F 441	Education was provided to CNA observed during the survey. Nursing staff completed a competency regarding donning and doffing gloves and hand washing during 2016. Standard Precautions Policy was reviewed with nursing staff. Audits will continue to be done - 5 hand washing audits each month and 5 glove use audits each month to monitor compliance with policy. Done by DON or designee. Results of audits will be presented to the QA committee.	

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F 441	Continued From page 45 directly on the floor. NA-E proceeded to wash R28's bottom, put on a clean pad, pants and shirt and then comb R28's hair, while still wearing the same pair of gloves. Without washing her hands, NA-E proceeded to change R28's television channel while still wearing the soiled gloves. During interview on 11/9/16, at 7:38 a.m. NA-E confirmed she did not change her gloves and wash her hands after cleansing R28's bottom and proceeding to finish his dressing and touch other objects such as the television in his room. During interview on 11/9/16, at 12:56 p.m. the director of nursing (DON) confirmed staff should be removing their gloves after providing personal cares when they become soiled and wash their hands before completing the remainder of the cares. The DON indicated they had been trying to audit handwashing on a monthly basis. The facility policy, entitled Standard Precautions Policy, dated 11/9/16 indicated gloves should be removed, discarded and replaced with a new pair after hand hygiene is completed, if gloves are contaminated, used from dirty to a clean area or torn and punctured.	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 466	Procedures to ensure water availability -	12/8/16

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F 466	Continued From page 46 facility failed to ensure it had a current procedure for the emergency provision of water which specified the amount of potable and non-potable water, a method for calculating the amounts of water required and the method of distribution. This has the potential to affect the 24 residents who reside in the facility. Findings include: During the entrance conference on 11/6/16, at 2:13 p.m. the director of nursing (DON) indicated the facility had a memo of understanding for its emergency water supply with Culligan for potable water. The DON indicated she would need to check with facilities management to get a copy. On 11/8/16, at 6:12 p.m. the DON provided a memo of understanding from Culligan Water of Fairmont for the provision of emergency potable water which indicated a needed rate of two gallons per day per person, but did not specify a method of distribution. The memo of understanding was dated 11/8/16. An additional Facility Memo of Understanding for Potable Water, copyrighted 2011 by Mayo Foundation for Medical Education and Research which was unsigned, indicated Viessman Trucking would provide clean potable water to Mayo Clinic Health System in Fairmont but lacked a method for calculating the amount and the method of distribution. During further interview on 11/9/16, at 12:56 p.m. the DON stated they had not been able to find the emergency water memo of understanding when asked to provide it, so the facility had one drawn up on 11/8/16.	F 466	Water Supply Policy for MCHS - Fairmont was update in November of 2016. Policies have been updated, and signatures received. Facilities Manager or designee will be responsible for this task. Update will be given to QA committee upon completion.	

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	245274	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 2012 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		12/07/2016

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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	245274	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2016**

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**

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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 25 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2016**

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K 341 SS=F	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the fire alram sysytem in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code.This deficient practice could affect 25 of the 25 residents. Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8.	K 341	During the survey on 11/9/16 it was noted that the annunciator on the 2nd floor was not working. Fire alarm annunciator panel at the 2nd floor nurses station is working properly. This panel functions and illuminates the alarm and location ONLY during an alarm. Thus, when not in alarm, the screen comes up blank. Facilities Manager or designee is responsible for updating literature to notify staff. QA committee will be notified at our next meeting.	12/8/16

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K 341	Continued From page 3 FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 11/09/2016, observation revealed the screen on the Fire Alarm Annunciator Panel at the 2nd Floor Nurses Station appeared not to functioning. This deficient practice was verified by the Facility Maintenance Director.	K 341		
K 354 SS=F	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. The deficient practice could affect 25 out of 25 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined,	K 354	Life Safety System Failure and Fire Watch program Procedure is updated. The new policy will be submitted to the QA committee at our next meeting. Facilities Manager or designee is responsible for this task.	12/8/16

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K 354	Continued From page 4 recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 11/09/2016, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current staff contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354		
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on documentation review and interview,	K 711	During the survey on 11/9/16 it was noted	12/8/16

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K 711	Continued From page 5 the Facility failed to maintain a Evacuation and Relocation Plan according to the 2012 Life Safety Code.This deficient practice could affect 25 of the 25 residents Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 11/09/2016, documentation review revealed the Emergency Fire Plan needs to be updated to ensure all the requirements of the 2012 Life Safety Code are addressed. This deficient practice was verified by the Facility Maintenance Director.	K 711	that MCHS - Fairmont Fire Safety Plan needed to be reviewed and updated. The policy has been updated to include the current Fire Marshall's contact info in case of any evacuation emergency. Facilities Manager or designee is responsible for this task. The QA committee will be updated at our next meeting regarding the revision of the policy.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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	K 712		12/8/16

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K 712	Continued From page 6 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 25 of 25 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. Findings include: On facility tour between 11:00 AM and 3:00 PM on 11/09/2016, documentation reviewed revealed that a fire drill was not conducted during the night shift in the 4th quarter (Oct-Dec) 2015. This deficient practice was verified by the Facility Maintenance Director.	K 712	Fire drills are ran each shift, quarterly for Lutz Wing. During further review of our records during the survey, it shows one fire drill was missed in 2015. Going forward, all drills will be measured and reported to the site EOC for review and follow up. Facilities Manager or designee is responsible for this task. QA Committee will be updated on status of fire drills at our next meeting.	
K 918	NFPA 101 Electrical Systems - Essential Electric	K 918		12/8/16

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K 918 SS=F	Continued From page 7 Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This	K 918	Monthly generator testing is done in accordance with regulations set forth by the Joint Commission and State Fire Marshal's office. During the survey it was	

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K 918	Continued From page 8 deficient practice could affect 25 of 25 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Findings include: On facility tour between 11:00 AM and 3:00 PM on 11/09/2016, documentation reviewed revealed	K 918	noted that we had not included on our form the cool down period, and the amount of time the generator provides power from the transfer. This has been added to our monthly generator log. Facilities Manager or designee is responsible for this task.	

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K 918	Continued From page 9 that not all the required information is being documented during the Month Emergency Generator Load Test. The transfer time of how long it takes the emergency generator to assume power and the amount of cool down time the generator is run after the load test is completed is not being recorded. This deficient practice was verified by the Facility Maintenance Director.	K 918		

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted

November 28, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5274026

Dear Mr. Corchran:

The above facility was surveyed on November 6, 2016 through November 9, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 6th, 7th, 8th and 9th, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan related to thrombocytopenia and risk for bleeding/bruising for 1 of 3 residents (R15) reviewed for non-pressure related skin conditions. Findings include: Review of R15's diagnosis report included diagnosis of thrombocytopenia (deficiency of platelets in the blood that causes bleeding into the tissues, bruising, and slow blood clotting after injury). On 11/6/16, at 2:22 p.m. R15 was observed to have two dime sized dark purple bruises with lighter purple bruising around the area	2 560	Corrected.	12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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) COMPLETE DATE
2 560	Continued From page 3	2 560		

approximately 3 centimeters (cm) in diameter. During interview with resident at this time, he stated he obtained the bruises when going through door ways, reaching and bumping right hand. On 11/9/16, at 11:38 a.m. R15 stated "I bruise easy".

Review of R15's physician orders dated 9/27/16 included an order for prednisone (a medication used to suppress the immune system with side effect of increased bruising tenancy) 10 milligrams (MG) by mouth in the morning for low platelets (parts in the blood that help the blood clot) and an order on 10/17/16 to decrease prednisone to 7.5 MG daily.

Review of R15's laboratory results from 9/6/16 to 10/31/16 indicate weekly platelet levels were drawn. R15's platelet results ranged from 22,000-32,000 per liter (L) with normal reference range of 150,000-450,000 platelets per L. Progress note indicated call from laboratory stating critical low platelet counts of 26,000 per L on 10/17/16.

Review of R15's care plan, revised 10/4/16, identified R15 as being at risk for pressure ulcers with risk factors including previous pressure ulcers, diagnosis, medications, use of a wheelchair (W/C) for primary mode of locomotion, and history of skin irritation. The care plan did not include R15 as being at risk for bleeding/bruising nor reference to the diagnosis of thrombocytopenia nor interventions related to bleeding/bruising.

During interview on 11/9/16, at 7:33 a.m. registered nurse (RN)-B indicated R15 has had a diagnosis of thrombocytopenia for over a year and was being treated with prednisone. Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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2 560	Continued From page 4 stated R15 had been having critically low platelet levels. RN-B verified the care plan lacked interventions related to R15's risk for bleeding/bruising, stating "that should've been in there". During interview on 11/9/16, at 12:50 p.m. director of nursing (DON) stated her expectation is that a care plan is developed when someone has a clotting disorder and risks of bleeding/bruising. The facility's policy Care Conferences Procedure- dated 4/5/16, indicated care conference day RN assists in developing a written plan of care for each resident that identifies the problems/need of the resident and the goals to be accomplished for each problem/need identified. Facility policy titled Care Conferences Policy- dated 4/5/16 indicated care plan components include: problem/need/strength statement, goal statement with target date, interventions/approaches, disciplines involved responsible for each intervention, care plan review and discontinuation dates. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures related to care plan development and educate staff related to the policy changes. The DON could audit resident care plans to ensure all pertinent nursing diagnoses are addressed, and report results to the quality assurance committee for follow up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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2 565	Continued From page 5 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care related to ambulation services for 4 of 4 residents (R28, R6, R15, R8) reviewed for activities of daily living (ADL) and failed to follow the plan of care related to repositioning for 1 of 1 resident (R8) reviewed for pressure ulcers (PU). Findings include: Ambulation: R28's quarterly Minimum Data Set (MDS) assessment dated 8/3/16, identified R28 required extensive assistance of two for transfers and limited assistance of two people for ambulation in the corridor. The MDS identified a diagnosis of non-Alzheimer's dementia. The MDS identified a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). R28's Care Area Assessment (CAA) related to ADL's dated 5/25/16, identified triggers due to needing assistance with cares, cognitive impairment and balance issues. R28's care plan last revised 10/4/16, indicated R28 required assistance of one staff with walking and locomotion, using a walker and wheelchair. R28 was to be encouraged to walk to and from meals and activities. R28's daily walking lists, from the previous 30-day	2 565	Corrected.	

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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2 565	Continued From page 6 period did not include any documented walks/ambulation. R28's physical therapy (PT) discharge instructions dated 3/7/16, indicated R28 was to ambulate to and from the dining room with staff assistance. During observation on 11/7/16, at 12:52 p.m. R28 wheeled himself from the dining room; R28 was not observed to be ambulated from the meal with staff assistance. During interview on 11/7/16, at 12:55 p.m. R28 stated, "There's a few girls that walk me everyday. I need to walk more so I'm not sitting all the time." During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for the noon meal and was not walked in accordance with the recommendation from the PT discharge orders. During observation on 11/8/16, at 12:31 p.m. R28 was observed to wheel himself to and from the noon meal; no staff offered to assist him with ambulation. During observation on 11/8/16, at 12:34 p.m. no walking program instructions or sheets were observed in R28's room. During interview on 11/8/16, at 3:30 p.m. the director of nursing (DON) stated that "ambulation is a deficiency of ours," and the facility was attempting to work on improving this task. The DON stated there should be a form inside of the resident's room to document exercise activity. The DON stated that walking to and from meals	2 565		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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2 565	Continued From page 7	2 565		

was during a busy time of day, and consequently another time of the day may work better.

During follow up interview on 11/8/16, at 4:02 p.m. the DON confirmed there was not a walking sheet nor exercise sheet located in R28's room at this time.

During observation of the breakfast meal on 11/9/16, at 8:21 a.m. R28 was observed to wheel himself to the dining room.

During observation of the breakfast meal on 11/7/16, at approximately 8:30 a.m. R6 was not observed to be ambulated to the morning meal.

During observation of the noon meal on 11/7/16, at 1:04 p.m. R6 was wheeled back to the room by visitors and was not offered by staff to ambulate.

R6's face sheet located in the medical record dated 11/8/16, identified diagnoses of osteoarthritis and an artificial right shoulder, as well as history of falls.

R6's care plan last updated 10/31/16, indicated R6 was to be walked- starting 10/31/16 to/from meals and activities with a wheeled walker and assist of one to two staff. Resident may not always walk full distance, do what she can.

R6's ambulation tracking sheets for the time period 10/31/16-11/6/16, included only an "X" on two of the seven days (11/5 and 11/6/16), with no distance recorded. The "X" indicated that R6 had walked.

R6's quarterly MDS dated 8/3/16, indicated R6 had a BIMS score of 13 (cognitively intact) and required extensive assistance of one staff for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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2 565	Continued From page 8	2 565		

locomotion.

R6's CAA for activities of daily living (ADLs)/functional rehabilitation potential dated 2/29/16, indicated R6 was at risk for decline due to weakness, intermittent pain and history of falls; Proceed to care plan to improve abilities related to ADLs.

During interview on 11/7/16, at 2:00 p.m. nursing assistant (NA)-A stated R6 had an exercise program and showed survey staff a binder including the ambulation tracking sheets for 10/31/16 -11/6/16 which indicated R6 had been walked to and from meals on 11/6/16. NA-F was also present and indicated she sometimes had a difficult time getting R6 to ambulate to the meals; stating R6 would "find a reason" not to walk.

During interview on 11/8/16, R6 stated she did not walk today and did not walk all day on 11/7/16. R6 did not indicate she had refused ambulation.

Review of R6's nursing progress notes for the time period of 10/31/16-11/9/16 did not reveal she had refused ambulation.

R15's quarterly MDS, dated 9/21/16 identified R15 required supervision and assist of one for transfers, and ambulated in room and corridor only once or twice during look back period with no set-up or physical help from staff. The MDS identified a BIMS score of 15 (cognitively intact).

R15's CAA for activities of daily living (ADL) dated 4/12/16, identified triggers due to needing assistance with his cares, and balance issues during transitions. R15's care plan revised 10/4/16, indicated R15 ambulated independently to needing supervision of one with a walker and

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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2 565	Continued From page 9 used a wheelchair for longer distances independently. R15 was listed on the daily walking list. The daily walking list instructed caregivers to ambulate R15 to/from meals following with wheelchair or in hallway. R15's daily walking list, from the previous 30-day period did not include any documented walks. When interviewed on 11/7/16, at 12:42 p.m. R15 stated he transfers self from his recliner chair to his wheelchair but further indicated he uses his wheelchair for locomotion. On 11/8/16, at 11:48 a.m. R15 was observed propelling self down hallway in his wheelchair to dining room for lunch. During interview on 11/9/16, at 11:43 a.m. NA-G stated R15 ambulates with a walker and one assist on the evening shift. During interview on 11/9/16, at 12:22 p.m. RN-B stated R15's family walks with him almost daily when they visit. RN-B indicated R15 used a walker and was followed by wheelchair with family. RN-B further stated R15 was not on a nursing ambulation program. R8's face sheet located in the medical record dated 11/9/16, identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and osteoarthrosis. R8's most current quarterly MDS dated 8/11/16, identified R8 required limited assistance of one staff person for transfers and walking in the corridor. The MDS also identified a BIMS score	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 10 of 13 (cognitively intact). R8's CAA related to ADL's dated 3/8/16, identified R8 triggered due to needing assistance with his activities of daily living, and having balance issues during transitions. Additional risk factors for decline in ADL's include a spinal cord injury with arm weakness, use of a walker and a wheelchair for locomotion; Proceed to care plan to avoid complications. R8's care plan last revised on 10/08/16 indicted R8 had limited physical mobility related to weakness, and was to walk around the square three to four times a day. R8's nursing progress notes for the months of 10/16 and 11/16 indicated R8 walked on 11/1/16 three times this evening with one staff assisting. On 10/28/16, R8 was documented to have walked once in the hallway at 8:10 p.m., no distance was charted. On 10/24/16, R8 was documented to ambulate twice that evening, with one assist. No distance was documented. On 10/23/16, R9 was documented to have charted twice that evening with one assist. On 10/19/16, R8 was documented to have ambulated twice with the nursing assistant in the hallways. No distance was charted. During observation on 11/8/16, at 1:03 p.m. R8 was observed seated in his wheelchair, playing cards with a visitor. During a continuous observation on 11/8/16, from 3:49 p.m. until 5:56 p.m., R8 was seated in the lobby playing dice games with other residents. R8 was not observed to be approached about talking a walk.	2 565		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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2 565	Continued From page 11 During interview on 11/8/16, at 4:47 p.m. NA-A indicated R8 should walk three to four times per day. NA-A stated the information should be charted on a sheet kept at the nursing station, which was blank for the current date as of this time (4:50 p.m.). During interview on 11/8/16, at 4:59 p.m. NA-C and NA-B indicated R8 should walk three to four times per day, which was documented on a walking list and transferred into the computer by RN-B at some point during the month. During interview on 11/8/16, at 5:04 p.m. R8 stated he had not walked all day today. During interview on 11/9/16, at 7:45 a.m. NA-D confirmed R8 should walk several times per day. During interview on 11/9/16, at 8:35 a.m., RN-B indicated R8 should be walking several times per day, and the results should be recorded on the walking sheets. RN-B provided the previous month's ambulation flow sheets at this time. However, it only included ten days of sheets which had been submitted. Of the ten days of walking sheets provided, R8 only walked 15 of 30 opportunities, or an average of once or twice daily. The walking sheets indicated R8 was to ambulate four times daily with a wheeled walker 200 feet with assistance of one staff. During further interview on 11/9/16, at 11:15 a.m. the DON indicated the walks were not put into the computer system, although sometimes they might be documented in the nursing progress notes, stating there currently was not really a good way of documenting ambulation. The DON confirmed it was expected staff would ambulate residents in accordance with the care plan.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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) COMPLETE DATE
2 565	Continued From page 12	2 565		

The facility policy, entitled Rehabilitative and Restorative Program, dated 11/8/16 indicated nursing care is directed toward conservation of abilities of residents, restoration of optimal levels of function and independence, adaptation to an altered life style, and prevention of deterioration, and complications of disability.

Repositioning:
R8's care area assessment (CAA) for pressure ulcers dated 3/8/16 identified R8 had risk factors for pressure ulcers and required a special seat cushion to reduce or relieve pressure, was immobile and incontinent, had altered mental state, and had a history of PU; Proceed to care plan to avoid complications.

R8's care plan dated 11/7/16 indicated R8 was at risk for PU related to needing extensive assistance with bed mobility, frequent urinary incontinence, assistance with ADL's and weakness. The care plan identified R8 was to be encouraged to off load every 15-20 minutes to the left side when possible through out the day while awake for pressure reduction.

R8's face sheet, dated 11/9/16 identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and urinary incontinence.

During interview on 11/6/16, at 2:02 p.m. registered nurse (RN)-A indicated R8 had a Stage II PU on his right buttock that had been present since 3/10/16, and was recurrent.

During observation and interview on 11/7/16, at 12:46 p.m. R8 stated he had a "pimple area" on

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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2 565	Continued From page 13 his bottom. R8 stated the staff repositioned him once or twice a day, and he could transfer himself in and out of the wheelchair to go to the bathroom. During observation on 11/8/16, at 1:03 p.m. R8 was seated in his wheelchair, playing cards in the lobby. During continuous observations on 11/8/16, from 3:49 to 5:56 p.m., R8 was noted to be seated in his wheelchair and was not observed to make significant changes in his position independently. No staff were observed to remind R8 to shift his weight (no offload). During interview on 11/8/16, at 5:56 p.m., R8 stated he stood up on his own about three or four times daily when he took himself to the bathroom and did not otherwise receive repositioning or reminders to shift his weight from staff. During interview on 11/8/16, at 4:47 p.m. nursing assistant (NA)-A indicated R8 walked three or four times during the day and was independent with transfers in his room. R8 did not receive routine repositioning from staff. During interview on 11/8/16, at 4:49 p.m. NA-B and NA-C indicated they were not aware of any skin concerns for R8. Both stated R8 repositioned himself during the day, was not reminded to reposition himself. During interview on 11/09/16, at 7:45 a.m. NA-A and NA-D stated R8 did not have any specific repositioning program while in the wheelchair. During observation on 11/9/16, at 12:25 p.m. R8's buttock ulcer was observed with RN-A, who	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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) COMPLETE DATE
2 565	Continued From page 14 confirmed the area was a Stage II PU, with an observed total area of 4 cm by 5 cm of redness with an open slit in the center which was noted shiny red tissue to the wound base, measuring 0.8 cm by 1 cm. During interview on 11/9/16, at 11:17 a.m. the DON indicated she thought R8 usually moved himself around enough in his chair and that staff were not encouraging him to reposition. The facility policy, entitled Integumentary System: Skin Integrity, dated 11/9/16 indicated patients will be assessed for risk of developing a skin alteration. Nursing will develop an individualized, interdisciplinary plan of care for prevention of altered skin integrity on hospitalized patients. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures related to ensuring the care plan is implemented and educate staff related to the policy changes. The DON could audit resident cares for completing in accordance with the care plan, and report results to the quality assurance committee for follow up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 15 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruising/bleeding for 1 of 3 residents (R15) reviewed for non-pressure related skin conditions. Findings include: Review of R15's diagnosis report included diagnosis of thrombocytopenia (deficiency of platelets in the blood that causes bleeding into the tissues, bruising, and slow blood clotting after injury). On 11/6/16, at 2:22 p.m. R15 was observed to have two dime sized dark purple bruises with lighter purple bruising around the area approximately 3 centimeters (cm) in diameter. During interview with resident at this time, he stated he obtained the bruises when going through door ways, reaching and bumping right hand. On 11/9/16, at 11:38 a.m. R15 stated, "I bruise easy". Review of R15's physician orders dated 9/27/16 included an order for prednisone (a medication used to suppress the immune system with a side effect of increased bruising tendency) 10 milligrams (mg) by mouth in the morning for low platelets (component of the blood that help the blood clot) and an order on 10/17/16 to decrease	2 830	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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2 830	Continued From page 16 prednisone to 7.5 mg daily. Review of R15's laboratory results from 9/6/16 to 10/31/16 indicate weekly platelet levels were drawn. R15's platelet results ranged from 22,000-32,000 per liter (L) with a normal reference range of 150,000-450,000 platelets per L. The progress note indicated a call from the laboratory indicating R15 had a critically low platelet count of 26,000 per L on 10/17/16. Review of R15's care plan, revised 10/4/16, identified R15 as being at risk for pressure ulcers with risk factors including previous pressure ulcers, diagnosis, medications, use of a wheelchair (w/c) for primary mode of locomotion, and history of skin irritation. The care plan did not include R15 as being at risk for bleeding/bruising, no reference to the diagnosis of thrombocytopenia nor include any interventions related to bleeding/bruising. During interview on 11/8/16, at 12:34 p.m. licensed practical nurse (LPN)-B stated on bath days new skin concerns would be noted and documented with measurements on skin sheet, and that it is also put into the medication administration record (MAR) to monitor daily until healed. A progress note is documented. LPN-B stated a bruise was identified on R15's right hand with bath today but had not completed a wound documentation sheet yet. During interview on 11/9/16, at 7:33 a.m. registered nurse (RN)-B indicated R15 has had diagnosis of thrombocytopenia for over a year and was being treated with prednisone, and further stated R15 had been having critical low platelet levels. RN-B verified no care plan nor interventions were identified related to R15's risk	2 830		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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2 830	Continued From page 17 for bleeding/bruising, stating "that should've been in there". During interview on 11/9/16, at 12:50 p.m. director of nursing (DON) indicated all non-pressure skin problems were to be documented on a wound documentation sheet which includes wound type, location, measurement, drainage, odor, and checking a box for updating care plan as needed. The DON stated her expectation was for it to be completed by licensed staff and that bruises would be documented weekly until resolved. The DON further stated the expectation was to have a care plan developed related to the clotting disorder so that staff could follow the identified plan. On 11/9/16, the facility provided copies of the 11/16 medication administration record (MAR) and treatment administration record (TAR). Review of the documents lacked any mention nor monitoring of the right hand bruise. In addition, review of R15's wound documentation dated 7/23/16 to 10/22/16, lacked any monitoring related to skin bruising. An undated facility form titled Nursing Checklist for Skin Alterations (i.e. Pressure Ulcers, Surgical, Vascular, Diabetic, Skin Tears, Bruises, Rashes) instructs to assess skin alteration and document the following: location, type of skin alteration, measurement, and add treatment to TAR for weekly measurement and documentation, develop, review and update care plan as interventions are added/changed/discontinued. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could revise current policies related to monitoring of	2 830		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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2 830	Continued From page 18 skin conditions and educate staff related to the changes. The DON or designee could audit skin conditions for proper documentation and monitoring and report results to the quality assurance committee for further follow-up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services to promote healing of a pressure ulcer (PU) for 1 of 1 resident (R8) reviewed who experienced a recurrent stage II pressure ulcer (defined as a partial-thickness loss of skin with exposed dermis, with a wound bed that is viable, pink or	2 900	Corrected.	12/8/16

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2 900	Continued From page 19 red, moist, and may also present as an intact or ruptured serum-filled blister). Findings include: R8's most current quarterly Minimum Data Set (MDS) assessment dated 8/11/16, identified R8 had two stage II pressure ulcers. The MDS also identified a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). R8's care area assessment (CAA) for pressure ulcers dated 3/8/16 identified R8 had risk factors for pressure ulcers and required a special seat cushion to reduce or relieve pressure, was immobile and incontinent, had altered mental state, and had a history of PU; proceed to care plan to avoid complications. R8's care plan dated 11/7/16, indicated R8 was at risk for pressure ulcers related to needing extensive assistance with bed mobility, frequent urinary incontinence, assistance with activities of daily living and weakness. The care plan identified R8 had a pressure ulcer on the right buttocks. Interventions included: assessing, monitoring and measurement of the wounds, treatments as ordered and encouraging R8 to off load [reduce pressure] every 15-20 minutes to the left side when possible throughout the day while awake for pressure reduction and use of wheelchair cushions. R8's face sheet, dated 11/9/16 identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and urinary incontinence. R8's most current Braden scale score (an assessment tool used to identify risk for	2 900		

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2 900	Continued From page 20	2 900		

development of pressure ulcers) dated 10/28/16, indicated a total scoring of 24 (maximum number of points should have be 23, friction risk score was indicated as a 4 out of a possible of only 3 points) which indicated R8 was not at risk for pressure ulcer development.

R8's wound documentation flow sheets for the time period of 3/10/16 through 11/6/16, indicated R8 initially started with a 2 centimeter (cm) by 2.6 cm hardened, red area on the right buttocks which intermittently healed over and re-opened with the most recent measurements documented on 10/23/16, indicated a wound bed which was 60% eschar (brown or black, non-viable tissue), 20% granulation (new connective tissue, usually of a darker red color that forms on the surface of a wound bed during healing) and 20% epithelial tissue (light pink colored tissue which forms during the wound healing process), which was measured 1.2 centimeters (cm) in size by 1.0 cm. A physical therapy (PT) progress note, dated 7/19/16 indicated R8 had a small, superficial laceration to the right upper buttock and would benefit from unweighting this area intermittently during the day, as well as to keep the area clean and covered. The PT progress note did not include any assessment of the wheelchair cushion/support surface.
During interview on 11/6/16, at 2:02 p.m. registered nurse (RN)-A indicated R8 had a stage II PU located on the right buttock that had been present since 3/10/16, which was recurrent.

During observation and interview on 11/7/16, at 12:46 p.m. R8 stated he had a "pimple area" on his bottom. R8 stated the staff repositioned him once or twice a day, and he could transfer himself in and out of the wheelchair to go to the bathroom. R8 stated he had a cushion in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 21	2 900		

wheelchair. R8 was seated on a blue colored, vinyl style seat cushion. R8 stated he did experience some discomfort on his buttock to the wound area while lying in bed at night. However, R8 indicated he did not have pain in the wound located on his buttock while seated in the wheelchair.

During observation with the surveyor on 11/7/16, at 1:02 p.m. licensed practical nurse (LPN)-A observed R8's PU. R8 wheeled himself into his bathroom, was able to stand up, hold onto the grab bar next to the toilet and to remain standing for his wound care. LPN-A donned gloves and removed a foam dressing from R8's buttocks, cleansed R8's buttocks with normal saline and patted dry. LPN-A removed her gloves, cleansed her hands and indicated R8 had a stage II pressure ulcer located on the right buttock. LPN-A reported it did not contain eschar. The area was observed to be primarily reddened with a very small slit in the center with non-adherent, flaking skin. LPN-A measured the entire area with redness as 4 cm x 5 cm. After measuring the wound, LPN-A applied a clean foam dressing to the ulcer. LPN-A indicated R8 had the current wheelchair cushion for quite awhile and was unsure whether a different cushion had been tried/reassessed since development of the PU.

During observation on 11/8/16, at 1:03 p.m. R8 was seated in his wheelchair, playing cards in the lobby. R8 demonstrated no verbal/non-verbal signs of discomfort.

During continuous observations on 11/8/16, from 3:49 to 5:56 p.m., R8 was noted to be seated in his wheelchair and was not observed to make significant changes in his position independently. No staff were observed to remind R8 to shift his

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2 900	Continued From page 22 weight during the observed timeframe. During interview on 11/8/16, at 5:56 p.m., R8 stated he stood up on his own about three or four times daily when he took himself to the bathroom and did not otherwise receive repositioning nor reminders from staff to shift his weight while seated. R8 indicated his wheelchair cushion had never been evaluated and/or changed after development of the buttock PU; however, stated "they sure could!" During interview on 11/8/16, at 4:47 p.m. nursing assistant (NA)-A indicated R8 walked three or four times during the day and was independent with transfers in his room. R8 did not receive routine repositioning from staff. During interview on 11/8/16, at 4:49 p.m. NA-B and NA-C indicated they were unaware of any skin concerns for R8. Both stated R8 repositioned himself during the day, was not reminded to reposition himself and that staff were to walk him several times per day. During interview on 11/09/16, at 7:45 a.m. NA-A indicated R8 should walk several times per day and was aware R8 did have a wound on his bottom. NA-D was present also at this time and stated R8 did not have any specific repositioning program while in the wheelchair. When interviewed on 11/9/16, at 8:35 a.m. RN-B (MDS Coordinator) indicated R8 was to walk several times per day. RN-B stated R8 had been provided with a new wheelchair due to the concern he was causing trauma to his ankles, bumping them into the wheels. RN-B confirmed she was unaware of any seat cushion changes since the development of R8's buttock ulcer.	2 900		

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2 900	Continued From page 23 During observation on 11/9/16, at 12:25 p.m. R8's buttock ulcer was observed with RN-A, who confirmed: the area was a stage II PU, the total area of 4 cm x 5 cm of redness had an open slit in the center with shiny red tissue extending to the wound base, which measured 0.8 cm by 1 cm. When interviewed on 11/9/16, at 11:17 a.m. the director of nursing (DON) indicated she thought R8 usually moved himself around enough in his chair and so staff were not encouraging him to reposition. The DON indicated they had not reassessed R8's ability to reposition himself adequately in the wheelchair since the PU developed. The DON thought the area was not in a location [on the buttock] R8 sat on, while in the wheelchair and was unaware of any recent changes in his wheelchair cushions. The facility policy, entitled Pressure Ulcer Management, dated 11/9/16 indicated pressure ulcers were assessed on admission, at initiation of treatment, with each dressing change or care intervention, upon transfer, and prior to discharge. The facility policy, entitled Integumentary System: Skin Integrity, dated 11/9/16 indicated patients will be assessed for risk of developing a skin alteration. Nursing will develop an individualized, interdisciplinary plan of care for prevention of altered skin integrity on hospitalized patients. The policy did not address other preventive measures for pressure ulcers beyond skin assessments and weekly wound documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	2 900		

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2 900	Continued From page 24 revise policies and procedures related to pressure ulcer development related to reassessment of risks and repositioning ability with changes in skin integrity. The DON or designee could educate staff related to the changes and audit resident care to ensure ongoing compliance. The DON or designee could report findings to the quality assurance committee for follow-up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 915	Corrected.	12/8/16

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2 915	Continued From page 25	2 915		

review, the facility failed to provide services necessary to maintain ambulation ability for 4 of 4 residents (R6, R8, R15, R28) reviewed for activities of daily living (ADL).

Findings include:

R28
R28's quarterly Minimum Data Set (MDS) assessment dated 8/3/16, identified R28 required extensive assistance of two for transfers and limited assistance of two people for ambulation in the corridor. The MDS identified a diagnosis of non-Alzheimer's dementia. The MDS identified a Brief Interview for Mental Status score of 13 (cognitively intact).

R28's Care Area Assessment (CAA) related to ADL's dated 5/25/16, identified triggers due to needing assistance with cares, cognitive impairment and balance issues; proceed to care plan and continue to assist with ADL's.

R28's care plan last revised 10/4/16, indicated R28 required assistance of one staff with walking and locomotion, using a walker and wheelchair. R28 was to be encouraged to walk to and from meals and activities.

R28's daily walking lists, from the previous 30-day period did not include any documented walks/ambulation.

R28's physical therapy (PT) discharge instructions dated 3/7/16, indicated R28 was to ambulate to and from the dining room with staff assistance.

During observation on 11/7/16, at 12:52 p.m. R28 wheeled himself from the dining room; R28 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 915	Continued From page 26	2 915		

not observed to be ambulated from the meal with staff assistance.

During interview on 11/7/16, at 12:55 p.m. R28 stated, "There's a few girls that walk me everyday. I need to walk more so I'm not sitting all the time."

During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for the noon meal and was not walked in accordance with the recommendation from the PT discharge orders.

During observation on 11/8/16, at 12:31 p.m. R28 was observed to wheel himself to and from the noon meal; no staff offered to assist him with ambulation.

During observation on 11/8/16, at 12:34 p.m. no walking program instructions or sheets were observed in R28's room.

During interview on 11/8/16, at 3:30 p.m. the director of nursing (DON) stated that "ambulation is a deficiency of ours," and the facility was attempting to work on improving this task. The DON stated there should be a form inside of the resident's room to document exercise activity. The DON stated that walking to and from meals was during a busy time of day, and consequently another time of the day may work better.

During follow up interview on 11/8/16, at 4:02 p.m. the DON confirmed there was not a walking sheet nor exercise sheet located in R28's room at this time.

During observation of the breakfast meal on 11/9/16, at 8:21 a.m. R28 was observed to wheel

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2 915	Continued From page 27 himself to the dining room. R6 During observation of the breakfast meal on 11/7/16, at approximately 8:30 a.m. R6 was not observed to be ambulated to the morning meal. During observation of the noon meal on 11/7/16, at 1:04 p.m. R6 was wheeled back to the room by visitors and was not offered by staff to ambulate. R6's face sheet located in the medical record dated 11/8/16, identified diagnoses of osteoarthritis and an artificial right shoulder, as well as history of falls. R6's care plan last updated 10/31/16, indicated R6 was to be walked- starting 10/31/16 to/from meals and activities with a wheeled walker and assist of one to two staff. Resident may not always walk full distance, do what she can. R6's ambulation tracking sheets for the time period 10/31/16-11/6/16, included only an "X" on two of the seven days (11/5 and 11/6/16), with no distance recorded. The "X" indicated that R6 had walked. R6's quarterly MDS dated 8/3/16, indicated R6 had a BIMS score of 13 (cognitively intact) and required extensive assistance of one staff for locomotion. R6's CAA for activities of daily living (ADLs)/functional rehabilitation potential dated 2/29/16, indicated R6 was at risk for decline due to weakness, intermittent pain and history of falls; Proceed to care plan to improve abilities related to ADLs.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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) COMPLETE DATE
2 915	Continued From page 28 During interview on 11/7/16, at 2:00 p.m. NA-A stated R6 had an exercise program and showed survey staff a binder including the ambulation tracking sheets for 10/31/16 -11/6/16 which indicated R6 had been walked to and from meals on 11/6/16. NA-F was also present and indicated she sometimes had a difficult time getting R6 to ambulate to the meals; stating R6 would "find a reason" not to walk. During interview on 11/8/16, R6 stated she did not walk today and did not walk all day on 11/7/16. R6 did not indicate she had refused ambulation. Review of R6's nursing progress notes for the time period of 10/31/16-11/9/16 did not reveal she had refused ambulation. R15 R15's quarterly MDS, dated 9/21/16 identified R15 required supervision and assist of one for transfers, and ambulated in room and corridor only once or twice during look back period with no set-up or physical help from staff. The MDS identified a BIMS score of 15 (cognitively intact). R15's CAA for activities of daily living (ADL) dated 4/12/16, identified triggers due to needing assistance with his cares, and balance issues during transitions. Additional risk factors included medication, history of falls, diagnosis, use of a walker and wheelchair for locomotion, occasional urinary incontinence and decreased hearing; Proceed to care plan to maintain current level of functioning. R15's care plan revised 10/4/16, indicated R15 ambulated independently to needing supervision of one with a walker and used a wheelchair for longer distances independently.	2 915		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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2 915	Continued From page 29	2 915		

R15 was listed on the daily walking list. The daily walking list instructed caregivers to ambulate R15 to/from meals following with wheelchair or in hallway. R15's daily walking list, from the previous 30-day period did not include any documented walks.

When interviewed on 11/7/16, at 12:42 p.m. R15 stated he transfers self from his recliner chair to his wheelchair but further indicated he uses his wheelchair for locomotion.

On 11/8/16, at 11:48 a.m. R15 was observed propelling self down hallway in his wheelchair to dining room for lunch.

During interview on 11/9/16, at 11:43 a.m. NA-G stated R15 ambulates with a walker and one assist on the evening shift.

During interview on 11/9/16, at 12:22 p.m. RN-B stated R15's family walks with him almost daily when they visit. RN-B indicated R15 used a walker and was followed by wheelchair with family. RN-B further stated R15 was not on a nursing ambulation program.

R8
R8's face sheet located in the medical record dated 11/9/16, identified current diagnoses of ankylosing spondylitis of the spine (arthritic inflammation of the joints of the spine which can affect gait and mobility) and osteoarthrosis.

R8's most current quarterly MDS dated 8/11/16, identified R8 required limited assistance of one staff person for transfers and walking in the corridor. The MDS also identified a BIMS score of 13 (cognitively intact).

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2 915	Continued From page 30 R8's CAA related to ADL's dated 3/8/16, identified R8 triggered due to needing assistance with his activities of daily living, and having balance issues during transitions. Additional risk factors for decline in ADL's include a spinal cord injury with arm weakness, use of a walker and a wheelchair for locomotion; Proceed to care plan to avoid complications. R8's care plan last revised on 10/08/16 indicted R8 had limited physical mobility related to weakness, and was to walk around the square three to four times a day. R8's nursing progress notes for the months of 10/16 and 11/16 indicated R8 walked on 11/1/16 three times this evening with one staff assisting. On 10/28/16, R8 was documented to have walked once in the hallway at 8:10 p.m., no distance was charted. On 10/24/16, R8 was documented to ambulate twice that evening, with one assist. No distance was documented. On 10/23/16, R9 was documented to have charted twice that evening with one assist. On 10/19/16, R8 was documented to have ambulated twice with the nursing assistant in the hallways. No distance was charted. During observation on 11/8/16, at 1:03 p.m. R8 was observed seated in his wheelchair, playing cards with a visitor. During a continuous observation on 11/8/16, from 3:49 p.m. until 5:56 p.m., R8 was seated in the lobby playing dice games with other residents. R8 was not observed to be approached about talking a walk. During interview on 11/8/16, at 4:47 p.m. NA-A	2 915		

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2 915	Continued From page 31 indicated R8 should walk three to four times per day. NA-A stated the information should be charted on a sheet kept at the nursing station, which was blank for the current date as of this time (4:50 p.m.). During interview on 11/8/16, at 4:59 p.m. NA-C and NA-B indicated R8 should walk three to four times per day, which was documented on a walking list and transferred into the computer by RN-B at some point during the month. During interview on 11/8/16, at 5:04 p.m. R8 stated he had not walked all day today. During interview on 11/9/16, at 7:45 a.m. NA-D confirmed R8 should walk several times per day. During interview on 11/9/16, at 8:35 a.m., RN-B indicated R8 should be walking several times per day, and the results should be recorded on the walking sheets. RN-B provided the previous month's ambulation flow sheets at this time. However, it only included ten days of sheets which had been submitted. Of the ten days of walking sheets provided, R8 only walked 15 of 30 opportunities, or an average of once or twice daily. The walking sheets indicated R8 was to ambulate four times daily with a wheeled walker 200 feet with assistance of one staff. During further interview on 11/9/16, at 11:15 a.m. the DON indicated the walks were not put into the computer system, although sometimes they might be documented in the nursing progress notes, stating there currently was not really a good way of documenting ambulation at this point in time. The DON confirmed it was expected staff would ambulate residents in accordance with the care plan.	2 915		

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2 915	Continued From page 32 The facility policy, entitled Rehabilitative and Restorative Program, dated 11/8/16 indicated nursing care is directed toward conservation of abilities of residents, restoration of optimal levels of function and independence, adaptation to an altered life style, and prevention of deterioration, and complications of disability. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could revise policies and procedures for documentation and implementation of ambulation programs and educate staff related to the changes. The DON or designee could audit resident ambulation programs for ongoing compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure pureed foods were held or served at the proper temperature to prevent foodborne illness for 4 of 4 residents (R16, R11, R19, R33) who had mechanically	21025	Corrected.	12/8/16

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21025	Continued From page 33 altered diets. Findings include: During observation of lunch meal on 11/8/16, at 11:54 a.m. dietary aide (DA)-A used a food thermometer to check the temperatures of the food in the steam table she was preparing to serve in the dining room. Food temperatures were recorded on the Daily Service log and DA-A began serving food onto trays. To the left side of the steam table area was a tray with four covered bowls of pureed chicken and biscuits. DA-A reported pureed food temperatures are not taken in dining room because it is checked in the kitchen and the pureed meals are kept in covered bowls on a tray located to side of steam table until served. DA-A further stated pureed meals are the last to be served during dish up. At 12:08 p.m. DA-A was ready to serve the bowls of pureed food when the surveyor requested a temperature check of the pureed chicken and biscuit. Upon completion, DA-A revealed a serving temperature of 110 and 111 degrees Fahrenheit (F) within the four bowls. DA-A explained that a serving temperature of 140 degrees F was desired, but since it was cooked already it was warm enough to serve, and proceeded to have the meals delivered. During interview on 11/8/16, at 3:23 p.m. the dietary manager (DM) stated after food is cooked to the temperature of 165 degrees F it is pureed, served into bowls, and delivered on a tray with other steam table food items. No holding nor serving temperature checks are routinely recorded once food has been pureed. At 4:01 p.m. the DM stated a safe serving temperature is 135 degrees (F) and confirmed that serving temperatures of pureed food at lunch today	21025		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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21025	Continued From page 34 (11/8/16) were below that. The DM verified the facility needs to make changes in their process related to mechanically altered food so that a safe serving temperature was ensured, including documenting the pureed food temperatures. An Untitled form provided by facility, last revised 8/2009, indicated hot product holding temperatures must be maintained at 140 degrees F or above while holding and serving. It further recommended serving temperatures of meat, poultry, seafood, eggs at 145-165 degrees F to ensure hot at point of consumption. SUGGESTED METHOD OF CORRECTION: The dietary manager could inservice staff on the importance of maintaining the temperature of pureed food and develop a system to ensure the food temperature is maintained after the food is mechanically altered. An audit could be implemented to ensure the temperature of the pureed food is within the appropriate range. The results of the audit could be presented to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to	21390		12/8/16

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21390	Continued From page 35 reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during personal cares for 1 of 1 resident (R28) observed during morning cares. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 8/3/16, indicated required extensive assistance for dressing and toileting and limited assistance with personal hygiene of one staff member. The MDS also identified R28 was frequently incontinent of urine. During observation on 11/09/16, at 7:05 a.m. nursing assistant (NA)-E was observed completing morning cares for R28. NA-E was observed to don gloves, walk R28 to the	21390	Corrected.	

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21390	Continued From page 36 bathroom, wash R28's back and underarms, then remove soiled bedding from R28's bed and lay it directly on the floor. NA-E proceeded to wash R28's bottom, put on a clean pad, pants and shirt and then comb R28's hair, while still wearing the same pair of gloves. Without washing her hands, NA-E proceeded to change R28's television channel while still wearing the soiled gloves. During interview on 11/9/16, at 7:38 a.m. NA-E confirmed she did not change her gloves and wash her hands after cleansing R28's bottom and proceeding to finish his dressing and touch other objects such as the television in his room. During interview on 11/9/16, at 12:56 p.m. the director of nursing (DON) confirmed staff should be removing their gloves after providing personal cares when they become soiled and wash their hands before completing the remainder of the cares. The DON indicated they had been trying to audit handwashing on a monthly basis. The facility policy, entitled Standard Precautions Policy, dated 11/9/16 indicated gloves should be removed, discarded and replaced with a new pair after hand hygiene is completed, if gloves are contaminated, used from dirty to a clean area or torn and punctured. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit resident cares for proper hand hygiene techniques and educate staff related to existing gloving and handwashing procedures. The DON could report results to the quality assurance committee for recommendations related to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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21535	Continued From page 37	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to evaluate the effectiveness and identify parameters for the use of as needed (PRN) pain medications (acetaminophen and Tramadol) for 1 of 5 residents (R23) reviewed for unnecessary medications. In addition, based on observation, interview and document review the facility failed to evaluate the effectiveness of PRN pain medications for 1 of 1 resident (R53)	21535	Corrected.	12/8/16

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21535	Continued From page 38 reviewed with pain. Findings include: R23 was admitted on 6/9/16, with diagnoses of chronic pain syndrome and history of left hip fracture per care plan. R23's signed physician orders dated 9/12/16, included orders for acetaminophen tablet 500 milligrams (mg) 2 tablets by mouth every 6 hours PRN pain or fever and Tramadol 50 mg by mouth every six hours PRN pain control. The quarterly Minimum Data Set (MDS) assessment dated 9/7/16, identified R23 as having a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition, and receiving PRN and non-medication interventions for pain. Pain assessment interview in the MDS further identifies R23 as having frequent pain rating it a 7 on 1-10 pain scale. Review of R23's care plan dated 9/15/16 included a goal indicating R23 would verbalize adequate relief of pain and instructed licensed and unlicensed nursing staff to monitor/document for side effects of pain medication, monitor /record pain characteristics PRN, Monitor/record/report to nurse any signs or symptoms of non-verbal pain, monitor/record/report to nurse loss of appetite, refusal to eat and weight loss. Review of R23's medication administration record (MAR) for October and November 2016 identified the following: - R23's MAR dated 10/16, identified R23 received 9 doses of PRN acetaminophen and 14 doses of PRN Tramadol during the month for	21535		

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	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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21535	Continued From page 39	21535		

discomfort. R23's Nurse's medication notes (tool used to monitor PRN medication effectiveness of administered medication) dated 8/30/16 to 11/7/16 identified spacing to record the date and time of PRN administration, medication, strength, dose, reason for administration provided and result from PRN medication given, time, and initials. However, there was no result/follow up documented on form to determine if the provided medication had been effective.

-R23's MAR dated 11/16, identified R23 received 4 doses of PRN acetaminophen and 3 doses of PRN Tramadol for discomfort. No result/follow up documented on form to determine if the provided medications had been effective.

Review of nursing progress notes dated 10/1/16 through 11/7/16 supported only three entries that identified no further complaints of pain after PRN administration of Tramadol 10/15/16, acetaminophen on 10/18/16, and Tramadol on 11/2/16.

During interview on 11/8/16, at 11:40 a.m. trained medication aide (TMA)-A stated if a resident requests a PRN medication, she notifies the charge nurse, and further stated PRN medications were not given by TMA's unless directed by the charge nurse on what medication to administer. At 11:42 a.m. registered nurse (RN)-C stated "its a nursing judgment call"; if the pain is rated less than 5 (pain scale 1-10) Tylenol is given and higher than 5 give the stronger medication. RN-C further indicated PRN's were to be documented on medication note form and assessed for effectiveness.

During interview on 11/8/16 at 4:34 p.m. RN-C verified PRN medications were not consistently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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21535	Continued From page 40	21535		

documented nor re-evaluated for effectiveness on the medication note form nor in nursing progress notes. RN-C also confirmed there were no parameters identified related to administration of acetaminophen vs. Tramadol.

During interview on 11/9/16, at 9:51 a.m. RN-A indicated it is a nursing judgement on which PRN pain medication to administer and further indicated there was no pain rating number across the board unless specifically ordered by the physician.

During interview on 11/9/16, at 12:48 p.m. director of nursing (DON) confirmed there is no consistent adminsitration of PRN pain medications without parameters for acetaminophen and Tramadol, and verified the lack of monitoring documentation for effectiveness once a PRN had been given. The DON stated her expectation was that more of the medical doctors would write the orders with a parameter, however, not all of them were doing it and staff had not been informed of this expectation yet.

During interview on 11/9/16, at 1:24 p.m. consultant pharmacist indicated she would expect pain medications to be clarified with a parameter and expect staff to review effectiveness of pain medications after given them.

R53's face sheet, dated 11/8/16 identified current diagnoses of end stage renal disease and a fracture of the left femoral neck and an admission date of 10/31/16.

R53's Minimum Data Set (MDS) assessment and Care Area Assessments (CAA) were in progress and not fully completed for for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21535	Continued From page 41 R53's pain assessment, undated and unsigned, indicated R53 had left hip surgical incision pain which was sharp in intensity. Tylenol, Vicodin and oxycodone were listed as medications used, with the most effective listed as oxycodone. R53's clinic referral form dated 11/3/16, indicated to administer Flexeril for muscle spasm and continue to work with physical therapy (PT). R53's physician's orders dated 11/1/16, indicated orders for oxycodone (a short acting narcotic pain medication) 5 milligrams (mg) every four hours as needed (PRN). R53's physician's orders dated 11/3/16, indicated orders for Flexeril (a muscle relaxant) 5 mg three times daily for seven days PRN for muscle spasm. R53's clinic referral dated 11/3/16 - Flexeril for muscle spasms, continue to work with PT, encourage to get tup and walk often. Order for Flexeril 5 mg po for 7 days PRN for muscle spasms. R53's medication sheets dated 11/16, indicated R53 had taken the Flexeril a total of ten times since it was ordered on 11/3/16, and had been receiving the oxycodone 5 mg on 28 occasions, on average four times/day since the order was received. The Lutz Wing Pain Progress notes, dated 11/16 which included documentation for pain levels with the as needed (PRN) pain medications only included documentation of the reason for the pain medication and/or a pain rating recorded on 12 occasions. Pain levels were listed ranging from 5- 7 (10 point rating scale). No follow up response	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	11/09/2016

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

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21535	Continued From page 42 or assessment of the pain level after the medication was administered was documented. During observation and on 11/7/16, at 12:29 p.m. R53 was seated in his room and indicated he had pain at a level of 5 (10 point scale) in his left leg, which was better than yesterday. However, R53 wished his pain level could be a zero and stated he last received oxycodone at 6:00 a.m. that morning. No non-verbal signs of pain were visualized at this time. During observation and interview on 11/8/16, at 12:30 p.m. R53 was seated on the side of his bed, eating lunch. R53 stated his pain was very bad right now, rating it 15. R53 was observed with facial grimacing and stated he had a "cramp" in his thigh and had just received oxycodone for pain. R53 also stated he had taken Flexeril for his muscle spasm as well. R53 stated the nurses are "right here," ever 4 hours to offer pain medication. R4 was noted to an ice pack applied on the left thigh at this time. During interview on 11/6/16, at 6:50 p.m. R53 stated he had just had a left hip replacement and was having pain in his left leg, which he rated a 7 (10 point scale). During interview on 11/7/16, at 1:36 p.m. registered nurse (RN)-D stated R53 was not always accepting of pain medications and had been somewhat depressed lately. RN-D stated staff asked him about his pain level with each medication pass and the trained medication assistants (TMA) staff should be doing so also. During interview on 11/8/16, at 12:41 p.m. RN-E indicated R53's fluid balance had been stable during dialysis and she had not noticed a	21535		

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21535	Continued From page 43 significant degree of pain during his dialysis treatments, stating R53 appeared "fairly comfortable." RN-E felt most of R53's pain was due to his recent orthopedic surgery. During interview on 11/8/16, at 1:09 p.m. licensed practical nurse (LPN)-B stated she monitored R53's pain level with medication passes and that R53 had tried hot and cold packs today for the left hip. LPN-B indicated nursing staff were trying to offer R53 the Flexeril 3 times/day on a more scheduled basis to see whether this helped his pain, which had increased the last couple of days. During interview on 11/8/16, at 3:25 p.m. the DON it was verified that staff should not only be charting pain levels when they give the pain medication, but also the follow up response to the pain medications on the PRN medication flow sheets so that staff could evaluate the effectiveness. During interview on 11/9/16, at 1:22 p.m. the consultant pharmacist (CP) indicated staff should be evaluating effectiveness of pain medications an hour or so after giving them, to monitor for effectiveness and this should be documented. The facility policy, entitled Pain Management, dated 7/2/14 indicated the patient's self-report is accepted as the most accurate measure of the current level of pain. A zero to ten numeric pain intensity scale was listed as an acceptable tool. For long term care settings, the policy indicated reassessment should occur after pain interventions, with a change in condition, a new report of pain, exacerbation of pain and at discharge or transfer to another level of care. The policy further stated this should be done in a timely manner according to the expected	21535		

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21535	Continued From page 44 outcomes for the intervention (e.g. efficacy of an opioid). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could work in conjunction with the consultant pharmacist to develop policies and procedures related to monitoring of pro re nata (PRN) medication use, parameters, and monitoring of effectiveness. The DON could educate staff related to these changes in policy and procedure, and audit resident records to ensure process changes are implemented. Results of audits could be reported to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		