DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GSPL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY	AGENCY		Facility ID: 00359
MEDICARE/MEDICAID PROVID NO.(L1) 245274 STATE VENDOR OR MEDICAID (L2) 259845104		3. NAME AND ADDRESS OF FACILITY (L3) MAYO CLINIC HEALTH SYSTEM - (L4) 800 MEDICAL CENTER DRIVE, PC (L5) FAIRMONT, MN			O BOX 800	56031	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SUPPLIER CATEGO 01 Hospital 05 HHA		ORY 09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY 12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	15/2016 ^{L34)} (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR END	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	40 (L18) 40 (L17)	Compliance1. A B. Not in Comp		am	2. Tech 3. 24 F 4. 7-Da	nnical Personnel	The Following Requirer 6. Scope of \$\frac{3}{2} 7. Medical E F) 8. Patient Ro 9. Beds/Roon (L12)	Services Limit Director om Size
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 40 (L37) (L38)	DWN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY 1		(L15)	
16. STATE SURVEY AGENCY REM				DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
Kathryn Serie, Unit Supe		-	2/29/2016	(L19)	Kamala Fiske-Downing, Enforcement Specialist 1/3/2016 (LIAL OFFICE OR SINGLE STATE AGENCY			
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OF	R SINGLE ST	TATE AGENCY	
19. DETERMINATION OF ELIGIBE 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITE HTS ACT:	H CIVIL	2. (ncial Solvency (HCFA-25) Interest Disclosure Strr:	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 04/01/1985	BEGINNINC		ENDING DA		VOLUNTARY 01-Merger, Clos	00	05-Fail to	UNTARY Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L25)			antary Termination	n <u>OTHER</u>	o Meet Agreement der Status Change
(L27)	B. Rescind Su	uspension Date:	(L44) (L45)				00-Activ	
28. TERMINATION DATE:	29	. INTERMEDIARY/	/CARRIER NO.		30. REMARKS			-
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION	N OF APPROVAL					
	(L32)			(L33)	DETERMIN	ATION APPR	ROVAL	



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	SIT
	B. Wing	YZ	2 1	12/15/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MAYO CLINIC HEALTH SYSTE	EM - 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).

ITE Y4	М		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. #	F0279 483.20(d), 483.2	20(k)(1)	Correction Completed	ID Prefix Reg. #		(k)(3)(ii)	Correction Completed	ID Prefix Reg. #	F0309 483.25		Correction Completed
LSC			12/08/2016	LSC			12/08/2016	LSC			12/08/2016
ID Prefix	F0311		Correction	ID Prefix	F0314		Correction	ID Prefix			Correction
Reg. #	483.25(a)(2)		Completed	Reg. #	483.25	(c)	Completed	Reg. #	483.25(I)		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			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. # LSC			Completed	Reg. # LSC			Completed	Reg. # LSC			Completed
REVIEWE STATE AC		REVIEW! (INITIALS		DATE 12/29/2	2016	SIGNATURE OF	SURVEYOR	03048		DATE 12/1	5/2016
REVIEWS CMS RO	ED BY	REVIEW!		DATE		TITLE				DATE	
FOLLOW 11/9/201	UP TO SURVE	COMPLE	ETED ON			R ANY UNCORRECTED DEFICIENCI				YE:	s 🗆 NO

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	'ISIT
IDENTIFICATION NUMBER 245274 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing	Υ	′2	12/19/2016	Y3
NAME OF FACILITY MAYO CLINIC HEALTH SYST	EM - FAIRMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 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).

ITE 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. #	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. #	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		-	
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/kfd	DATE 12/29/2016	SIGNATURE OF SURVEYOR	35482	DATE 12/	19/2016	
REVIEWS 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

ID: GSPL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY.	AGENCY		Facility	y ID: 00359
NO.(L1) 245274	STATE VENDOR OR MEDICAID NO. (L2) 259845104 EFFECTIVE DATE CHANGE OF OWNERSHIP		3. NAME AND ADDRESS OF FACILITY (L3) MAYO CLINIC HEALTH SYSTEM (L4) 800 MEDICAL CENTER DRIVE, PO (L5) FAIRMONT, MN					4. TYPE OF 1. Initial 3. Termina 5. Validatio 7. On-Site	2. tion 4. on 6.	2(L8) Recertification CHOW Complaint
5. EFFECTIVE DATE CHA(L9)	NGE OF OW	/NERSHIP	7. PROVIDER/SUPPLIER CATEGO 01 Hospital 05 HHA		GORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 8. ACCREDITATION STAT 0 Unaccredited 2 AOA		/2016 L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE		FISCAL YEAI		ATE: (L35)
11LTC PERIOD OF CERT From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	IFICATION	40 (L18) 40 (L17)	Compliance1. A X B. Not in Con	equirements e Based On:	gram	2. Tecl 3. 24 F 4. 7-D.	hnical Personnel	7. Me	ope of Services dical Director tent Room Size	
14. LTC CERTIFIED BED B	BREAKDOW	N				15. FACILITY	MEETS			
18 SNF 18	3/19 SNF 40	19 SNF	ICF	IID		1861 (e) (1) o	r 1861 (j) (1):	(L1	5)	
(L37)	(L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGEN	NCY REMAR	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):					
17. SURVEYOR SIGNATU	RE		Date :			18. STATE SUI	RVEY AGENCY	APPROVAL	Ε	Date:
Holly Kranz, HFE	NE II		1	2/09/2016	(L19)	Kamala Fiske	e-Downing, E	Enforcement	Specialist	12/29/2016 (L20)
	PART	II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE O	R SINGLE S	TATE AGEN	CY	
19. DETERMINATION OF				IPLIANCE WITI HTS ACT:	H CIVIL	2. (Ownership/Contro	ncial Solvency (HO		1- 1513)
1. Facility is E	· ·	ıcıpate				3. I	Both of the Above	::		
2. Facility is r	iot Engible	(L21)								
22. ORIGINAL DATE		23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	ATION ACTION:		(L30)	
OF PARTICIPATION 04/01/1985		BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos			IVOLUNTARY -Fail to Meet H	
(L24)		(L41)		(L25)		02-Dissatisfaction	on W/ Reimburse	ement 06	-Fail to Meet A	greement
25. LTC EXTENSION DATE	ГЕ: 2		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Invol 04-Other Reason	untary Terminatio n for Withdrawal	<u>0</u> 07	<u>THER</u> '-Provider Statu)-Active	us Change
	(L27)	B. Rescind Su	spension Date:	, ,						
				(L45)						
28. TERMINATION DATE	:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
			03001							
		(L28)			(L31)					
31. RO RECEIPT OF CMS-	1539	32	. DETERMINATION	OF APPROVAI	DATE					
		(I.32)			(I.33)	DETEDMIN	ATION ADDI	POWI		



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 12/09/2016 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE COMP	SURVEY PLETED
		245274	B. WING _		11/09/2016	
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 80 FAIRMONT, MN 56031	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT		F 00	00		
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are our signature is not required irist page of the CMS-2567 ic submission of the POC will cion of compliance.				
F 279 SS=D	on-site revisit of you validate that substa		F 27	79		12/8/16
36-2	A facility must use t	he results of the assessment and revise the resident's				
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	tdescribe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment).				
ABORATOR)	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			SURVEY PLETED		
		245274	B. WING _			11/0	09/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT		800 MEDICAL FAIRMONT,	CENTER DRIVE, PO BOX 800 MN 56031)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From particles and continued From p	ge 1 NT is not met as evidenced ion, interview and document filed to develop a care plan eytopenia and risk for or 1 of 3 residents (R15) ressure related skin conditions. Agnosis report included pocytopenia (deficiency of d that causes bleeding into g, and slow blood clotting after p.m. R15 was observed to d dark purple bruises with	F 2	Care Plato include to be mo Nurses hexpectati treatmen any reside plan. Audits witwice, motwice to replan police DON or contractions.	DEFICIENCY) an for Resident # 15 was use the diagnosis and interve	ipdated entions on for care er week rterly le care by	DATE
	effect of increased milligrams (MG) by platelets (parts in the clot) and an order of prednisone to 7.5 M Review of R15's late 10/31/16 indicate w	bruising tenancy) 10 mouth in the morning for low ne blood that help the blood on 10/17/16 to decrease					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245274	B. WING		11	/09/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279	range of 150,000-Progress note indistating critical low on 10/17/16. Review of R15's cidentified R15 as with risk factors in ulcers, diagnosis, wheelchair (W/C) locomotion, and h plan did not includ bleeding/bruising of thrombocytoper bleeding/bruising. During interview or egistered nurse (diagnosis of thromand was being trestated R15 had be levels. RN-B verificinterventions relationately bleeding/bruising, there". During interview of nursing (DON) care plan is develoclotting disorder a The facility's policy dated 4/5/16, indicassists in develop each resident and the each problem/nee	age 2 Iliter (L) with normal reference 450,000 platelets per L. cated call from laboratory platelet counts of 26,000 per L are plan, revised 10/4/16, peing at risk for pressure ulcers cluding previous pressure medications, use of a for primary mode of istory of skin irritation. The care e R15 as being at risk for nor reference to the diagnosis hia nor interventions related to n 11/9/16, at 7:33 a.m. RN)-B indicated R15 has had a abocytopenia for over a year ated with prednisone. Further having critically low platelet ed the care plan lacked ed to R15's risk for stating "that should've been in n 11/9/16, at 12:50 p.m. director stated her expectation is that a apped when someone has a and risks of bleeding/bruising. y Care Conferences Procedure- tated care conference day RN ing a written plan of care for identifies the problems/need of the goals to be accomplished for didentified. Facility policy titled to Policy- dated 4/5/16 indicated	F 279				

			DATE SURVEY COMPLETED		
		245274	B. WING		11/09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT	8	STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 279	with target date, int disciplines involved intervention, care p dates.	ents include: ngth statement, goal statement erventions/approaches, d responsible for each plan review and discontinuation	F 279		
F 282 SS=E	PERSONS/PER CA The services provided by	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of	F 282		12/8/16
	by: Based on observareview, the facility frelated to ambulation (R28, R6, R15, R8) living (ADL) and fairelated to reposition reviewed for presson Findings include: Ambulation: R28's quarterly Minassessment dated extensive assistance of the corridor. The Monon-Alzheimer's de Brief Interview for M13 (cognitively intactive)	nimum Data Set (MDS) 8/3/16, identified R28 required ce of two for transfers and of two people for ambulation in MDS identified a diagnosis of ementia. The MDS identified a Mental Status (BIMS) score of		Resident # 28 - Ambulation was added 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 loadin 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 residents during their shift and monitor proper charting.	g o ne on

NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT (XA) 10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUILL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 37/16, 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 edining 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 12:55 p.m. R28 wheeled himself to and from the dining room for	-	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAYO CLINIC HEALTH SYSTEM - FAIRMONT (A41) DEFICIENCY STATE APPROPRIATE DEPOSE SOM MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031 (A41) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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; R28 was not observed to be ambulated from the meal with staff assistance. During observation on 11/7/16, at 12:55 p.m. R28 wheeled himself from the dining room for stating in the time." During observation on 11/7/16, at 12:55 p.m. R28 wheeled himself from the dining room for stating all the time."			245274	B. WING		····	11/0	09/2016
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 the dining room with staff assistance. During observation on 11/7/16, at 12:55 p.m. R28 wheeled himself from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled himself to and from the dining room for During observation on 11/7/16, at 1:55 p.m. R28 wheeled	NAME OF I	PROVIDER OR SUPPLIER						
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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 observation 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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
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	needing assistance impairment and bal last revised 10/4/16 assistance of one solocomotion, using a was to be encourage and activities. R28's daily walking period did not include walks/ambulation. R28's physical them instructions dated 3 ambulate to and from assistance. During observation wheeled himself from the observed to be staff assistance. During interview on stated, "There's a freeveryday. I need to the time." During observation wheeled himself to the noon meal and with the recommen orders. During observation was observed to who moon meal; no staff ambulation.	with cares, cognitive ance issues. R28's care plan is, indicated R28 required taff with walking and a walker and wheelchair. R28 ged to walk to and from meals lists, from the previous 30-day de any documented apy (PT) discharge by (PT) discharge	F 2	282	Nurses have been taught to add R ambulation and off loading to treate plan in PointClickCare for CNAs to and be aware of rehabilitation plan Nurses will continue to add rehab programs to care plans. Audits will be completed every othe times 2; monthly times 2 and quart times 2 to monitor compliance with charting and completing rehab plan residents. Done by DON or design Results of audits will be presented	ment chart s. er week erly ns for	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		COMPLETED		
		245274	B. WING _		11.	/09/2016		
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031		90,2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 282	observed in R28's in During interview on director of nursing is a deficiency of or attempting to work DON stated there is resident's room to of The DON stated the was during a busy if another time of the During follow up into p.m. the DON confisheet nor exercise this time. During observation 11/9/16, at 8:21 a.n. himself to the dining observation 11/7/16, at approximation observed to be amble During observation at 1:04 p.m. R6 was visitors and was not R6's face sheet lock dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not R6's face sheet lock dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not R6's face sheet lock dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and was not dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and dated 11/8/16, identification of the dining observation at 1:04 p.m. R6 was visitors and dated 11/8/16, identif	structions or sheets were froom. 11/8/16, at 3:30 p.m. the (DON) stated that "ambulation urs," and the facility was on improving this task. The should be a form inside of the document exercise activity. at walking to and from meals time of day, and consequently day may work better. Terview on 11/8/16, at 4:02 irmed there was not a walking sheet located in R28's room at of the breakfast meal on n. R28 was observed to wheel groom. of the breakfast meal on mately 8:30 a.m. R6 was not bulated to the morning meal. of the noon meal on 11/7/16, s wheeled back to the room by t offered by staff to ambulate. ated in the medical record tified diagnoses of an artificial right shoulder, as	F 28	32				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245274	B. WING		11	/09/2016	
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP 800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 282	always walk full dis R6's ambulation traperiod 10/31/16-11, two of the seven dadistance recorded. walked. R6's quarterly MDS had a BIMS score of required extensive locomotion. R6's CAA for activiti (ADLs)/functional received extensive locomotion. R6's CAA for activiti (ADLs)/functional received to care plate to weakness, intermediate to weakness, intermediate to weakness, intermediate to ADLs. During interview on assistant (NA)-A staprogram and shown including the ambute 10/31/16 -11/6/16 veaked to and from also present and in difficult time getting stating R6 would "fit During interview on walk today and did R6 did not indicate. Review of R6's nurstime period of 10/3 had refused ambulations.	tance, do what she can. acking sheets for the time (6/16, included only an "X" on ays (11/5 and 11/6/16), with no The "X" indicated that R6 had action dated 8/3/16, indicated R6 of 13 (cognitively intact) and assistance of one staff for dies of daily living ehabilitation potential dated R6 was at risk for decline due nittent pain and history of falls; an to improve abilities related 11/7/16, at 2:00 p.m. nursing ated R6 had an exercise ed survey staff a binder lation tracking sheets for which indicated R6 had been meals on 11/6/16. NA-F was dicated she sometimes had a R6 to ambulate to the meals; and a reason" not to walk. 11/8/16, R6 stated she did not not walk all day on 11/7/16. she had refused ambulation. sing progress notes for the 1/16-11/9/16 did not reveal she	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245274	B. WING		11	/09/2016	
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 282	R15 required super transfers, and amb only once or twice set-up or physical identified a BIMS set. R15's CAA for actide 4/12/16, identified assistance with his during transitions. 10/4/16, indicated to needing superviused a wheelchair independently. R15 was listed on walking list instructo/from meals followalking list instructo/from meals followalking. R15's dai 30-day period did walks. When interviewed stated he transfers his wheelchair for locoron of 11/8/16, at 11:4 propelling self down dining room for lure dining interview of stated R15 ambulated R15 ambulated R15's family when they visit. R1 when they visit. R1 with supervisits R1 services of the services	ervision and assist of one for culated in room and corridor during look back period with no help from staff. The MDS score of 15 (cognitively intact). vities of daily living (ADL) dated triggers due to needing scares, and balance issues R15's care plan revised R15 ambulated independently ision of one with a walker and for longer distances the daily walking list. The daily ted caregivers to ambulate R15 owing with wheelchair or in ly walking list, from the previous not include any documented on 11/7/16, at 12:42 p.m. R15 a self from his recliner chair to further indicated he uses his omotion. 48 a.m. R15 was observed on hallway in his wheelchair to inch.	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245274	B. WING _	· · · · · · · · · · · · · · · · · · ·	11.	/09/2016	
-	OVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CO 800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031	ODE		
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fr F C a iii s C C C F F a iii s t v v v t t t t t t t t t t t t t t t	Rays face sheet local dated 11/9/16, identified 11/9/16, identified gait and mobility of the staff person for transcorridor. The MDS of 13 (cognitively in Rays CAA related to activities of daily lives a sues during transcorridor. The MDS or decline in ADL's with arm weakness wheelchair for loco of avoid complication. Rays care plan last Rays had limited phyweakness, and was hree to four times Rays nursing progress of the sues of the s	er stated R15 was not on a program. Eated in the medical record stified current diagnoses of litis of the spine (arthritic pioints of the spine which can stility) and osteoarthrosis. Quarterly MDS dated 8/11/16, red limited assistance of one insfers and walking in the state also identified a BIMS score state). Diagnostic ADL's dated 3/8/16, identified a needing assistance with his ring, and having balance stitions. Additional risk factors is include a spinal cord injury state of a walker and a motion; Proceed to care plan ons. Tevised on 10/08/16 indicted sical mobility related to sto walk around the square	F 28				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245274	B. WING _		11/0	9/2016		
	AME OF PROVIDER OR SUPPLIER IAYO CLINIC HEALTH SYSTEM - FAIRMONT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 9 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, fr 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 peday. 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			STREET ADDRESS, CITY, STATE, ZIP COD 800 MEDICAL CENTER DRIVE, PO BO FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 282	R8 was documents with the nursing as distance was chart During observation was observed seat cards with a visitor During a continuous 3:49 p.m. until 5:56 lobby playing dice R8 was not observialking a walk. During interview or indicated R8 should day. NA-A stated to charted on a sheet which was blank for time (4:50 p.m.). During interview or and NA-B indicated times per day, which walking list and trans RN-B at some point During interview or stated he had not work to be a should day, and the result walking sheets. RI month's ambulation	ed to have ambulated twice sistant in the hallways. No ed. I on 11/8/16, at 1:03 p.m. R8 ed in his wheelchair, playing . Is observation on 11/8/16, from 5 p.m., R8 was seated in the games with other residents. ed to be approached about an 11/8/16, at 4:47 p.m. NA-A d walk three to four times per he information should be kept at the nursing station, or the current date as of this	F 28					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11/	09/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 282	which had been sumalking sheets proportunities, or an daily. The walking ambulate four time 200 feet with assist During further intended the DON indicated computer system, be documented in stating there curre of documenting an it was expected state accordance with the The facility policy, Restorative Programursing care is directly abilities of resident of function and indultered life style, and complications. Repositioning: Repositioning: Resident of function and indultered life style, and complications. Repositioning: Repositioning: Resident of resident of function and indultered life style, and and complications. Repositioning: Resident of resident of function and indultered life style, and altered life style, and complications. Repositioning: Resident of resident of function and inconstate, and had a highan to avoid complication. Resident of resident of function and inconstate, and had a highan to avoid complication. Resident of resident of function and inconstate, and had a highan to avoid complication. Resident of resident of function and inconstate, and had a highan to avoid complication. Resident of resident of function and inconstate, and had a highan to avoid complication. Resident of resident of function and inconstate, and had a highan to avoid complication. Resident of resident of function and inconstate of function and inconst	submitted. Of the ten days of povided, R8 only walked 15 of 30 on average of once or twice sheets indicated R8 was to es daily with a wheeled walker stance of one staff. Tryiew on 11/9/16, at 11:15 a.m. the walks were not put into the although sometimes they might the nursing progress notes, ntly was not really a good way abulation. The DON confirmed aff would ambulate residents in the care plan. The tried Rehabilitative and am, dated 11/8/16 indicated ected toward conservation of ts, restoration of optimal levels dependence, adaptation to an and prevention of deterioration, of disability. The tried Rehabilitative and and prevention of optimal levels dependence, adaptation to an and prevention of deterioration, of disability. The tried Rehabilitative and and prevention of optimal levels dependence, adaptation to an and prevention of deterioration, of disability.	F 28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11	/09/2016	
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	left side when poss awake for pressure R8's face sheet, dadiagnoses of ankyle (arthritic inflammati which can affect gaincontinence. During interview on registered nurse (RII PU on his right busince 3/10/16, and During observation 12:46 p.m. R8 state his bottom. R8 state once or twice a day in and out of the whoathroom. During observation was seated in his whoth was seated in his whoth who staff were obseweight (no offload). During interview on stated he stood up times daily when he and did not otherwireminders to shift here.	ible through out the day while reduction. Ited 11/9/16 identified current osing spondylitis of the spine on of the joints of the spine it and mobility) and urinary 11/6/16, at 2:02 p.m. IN)-A indicated R8 had a Stage attock that had been present was recurrent. and interview on 11/7/16, at ed he had a "pimple area" on ted the staff repositioned him and he could transfer himself neelchair to go to the on 11/8/16, at 1:03 p.m. R8 wheelchair, playing cards in the observations on 11/8/16, from R8 was noted to be seated in was not observed to make in his position independently.	F 28	32			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245274	B. WING _		11/	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 8 FAIRMONT, MN 56031	NTER DRIVE, PO BOX 800	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	assistant (NA)-A incomposition four times during the with transfers in his routine repositioning. During interview on and NA-C indicated skin concerns for Repositioned himself reminded to reposit. During interview on and NA-D stated Repositioning program. During observation buttock ulcer was occonfirmed the area observed total area with an open slit in shiny red tissue to to 0.8 cm by 1 cm. During interview on DON indicated she himself around enowere not encouraging the state of the state o	dicated R8 walked three or e day and was independent room. R8 did not receive g from staff. 11/8/16, at 4:49 p.m. NA-B they were not aware of any 8. Both stated R8 f during the day, was not ion himself. 11/09/16, at 7:45 a.m. NA-A 8 did not have any specific am while in the wheelchair. on 11/9/16, at 12:25 p.m. R8's bserved with RN-A, who was a Stage II PU, with an of 4 cm by 5 cm of redness the center which was noted he wound base, measuring 11/9/16, at 11:17 a.m. the thought R8 usually moved ugh in his chair and that staff ng him to reposition.	F 28	32		
F 309 SS=D	Skin Integrity, dated be assessed for risi alteration. Nursing interdisciplinary pla altered skin integrity 483.25 PROVIDE O HIGHEST WELL B	entitled Integumentary System: d 11/9/16 indicated patients will k of developing a skin will develop an individualized, n of care for prevention of y on hospitalized patients. CARE/SERVICES FOR EING receive and the facility must ary care and services to attain	F 30	09		12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245274	B. WING		11/09	9/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	or maintain the hig mental, and psycho accordance with th and plan of care.	age 13 hest practicable physical, psocial well-being, in e comprehensive assessment NT is not met as evidenced	F 309			
	by: Based on observa review the facility fa bruising/bleeding freviewed for non-p Findings include: Review of R15's di diagnosis of throm platelets in the block	tion, interview and document		Resident s bruises have been documented on skin assessment for and care plan has been updated. Nurses were instructed on use of N Checklist for Skin alterations. Audits will be completed every wee 2; every other week times 2; month times 2; and quarterly times 2 to en compliance with documentation of alterations and updating the residence plan. Done by DON or designer Results of audits will be presented QA committee.	lursing k times ly sure skin nt s	
	have two dime size lighter purple bruis approximately 3 ce During interview wi stated he obtained through door ways	2 p.m. R15 was observed to ed dark purple bruises with ing around the area entimeters (cm) in diameter. Ith resident at this time, he the bruises when going , reaching and bumping right at 11:38 a.m. R15 stated, "I		QA committee.		
	included an order f used to suppress the effect of increased milligrams (mg) by platelets (compone	nysician orders dated 9/27/16 or prednisone (a medication he immune system with a side bruising tendency) 10 mouth in the morning for low ent of the blood that help the order on 10/17/16 to decrease				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245274	B. WING			11/0	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		80	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	prednisone to 7.5 n Review of R15's lat 10/31/16 indicate w drawn. R15's plate 22,000-32,000 per reference range of L. The progress not laboratory indicating platelet count of 26 Review of R15's catidentified R15 as be with risk factors inculcers, diagnosis, n wheelchair (w/c) for and history of skin in not include R15 as bleeding/bruising, rof thrombocytopeni related to bleeding/ During interview on licensed practical indays new skin conduction documented with mand that it is also pradministration reconhealed. A progress stated a bruise was with bath today but documentation she During interview on registered nurse (R diagnosis of thromband was being treafurther stated R15 light and was being treafurthe	oratory results from 9/6/16 to reekly platelet levels were let results ranged from liter (L) with a normal 150,000-450,000 platelets per ote indicated a call from the gR15 had a critically low,000 per L on 10/17/16. The plan, revised 10/4/16, eing at risk for pressure ulcers luding previous pressure nedications, use of a primary mode of locomotion, rritation. The care plan did being at risk for the diagnosis a nor include any interventions bruising. 11/8/16, at 12:34 p.m. urse (LPN)-B stated on bath the rens would be noted and neasurements on skin sheet, at into the medication rd (MAR) to monitor daily until a note is documented. LPN-B identified on R15's right hand had not completed a wound	F3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245274	B. WING _		11/	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 80 FAIRMONT, MN 56031	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	for bleeding/bruising in there". During interview on of nursing (DON) in problems were to b documentation she location, measurem checking a box for The DON stated he completed by licens would be document DON further stated care plan developed disorder so that state plan. On 11/9/16, the faci 11/16 medication as and treatment admit Review of the document and treatment admit Review of R15's wo 7/23/16 to 10/22/16 related to skin bruis An undated facility for Skin Alterations Surgical, Vascular, Rashes) instructs to document the follow alteration, measure TAR for weekly meadocumentation, developlan as intervention	dentified related to R15's risk g, stating "that should've been and that should've been and that should've been are documented on a wound the which includes wound type, tent, drainage, odor, and updating care plan as needed. The expectation was for it to be seed staff and that bruises are weekly until resolved. The the expectation was to have a direlated to the clotting are could follow the identified and that bruises. In addition, und documentation dated any mention nor ght hand bruise. In addition, und documentation dated any monitoring sing. Form titled Nursing Checklist (i.e. Pressure Ulcers, Diabetic, Skin Tears, Bruises, assess skin alteration and wing: location, type of skin ment, and add treatment to asurement and relop, review and update care is are	F 30	09		
F 311	added/changed/disc 483.25(a)(2) TREA	TMENT/SERVICES TO	F 3	11		12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11/0	9/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 80 FAIRMONT, MN 56031	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 311 SS=E	services to maintain specified in paragra. This REQUIREMENT by: Based on observatoreview, the facility for necessary to maintain residents (R28, R6, activities of daily living frindings include: R28 R28's quarterly Minassessment dated a extensive assistance of the corridor. The Monn-Alzheimer's de Brief Interview for Maintain 13 (cognitively intactive paragraph of the corridor of the corridor of the corridor. The Monn-Alzheimer's de Brief Interview for Maintain 13 (cognitively intactive paragraph of the corridor of the	the appropriate treatment and nor improve his or her abilities uph (a)(1) of this section. AT is not met as evidenced ion, interview and document ailed to provide services ain ambulation ability for 4 of 4 R15, R8) reviewed for ing (ADL). imum Data Set (MDS) 8/3/16, identified R28 required se of two for transfers and of two people for ambulation in IDS identified a diagnosis of mentia. The MDS identified a Mental Status (BIMS) score of etc. sessment (CAA) related to 6, identified triggers due to with cares, cognitive ance issues; proceed to care of assist with ADL's. trevised 10/4/16, indicated ance of one staff with walking ng a walker and wheelchair. buraged to walk to and from	F 31	All residents are assessed quarter during the MDS process for any chapter ADL function. CNAs are aware to notify charge nowith any changes in residents' ADL function. All residents with ambulation prograwill be audited as described. CNAs have been updated on residanbulation programs and taught produmentation. Care plans have brupdated. Documentation of ambulation programill be updated in PointClickCare freasier documentation for CNAs Audits will be completed weekly times and quarterly times 2 to monitor compliance with ambulation program Done by DON or designee. Results audits will be presented to the QA committee.	urse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245274	B. WING			11/0	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		800 M	ET ADDRESS, CITY, STATE, ZIP CODE IEDICAL CENTER DRIVE, PO BOX 80 MONT, MN 56031	-	0, =0.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	period did not incluwalks/ambulation. R28's physical their instructions dated ambulate to and from assistance. During observation wheeled himself from the observed to be staff assistance. During interview or stated, "There's a feveryday. I need to the time." During observation wheeled himself to the noon meal and with the recomment orders. During observation was observed to with the noon meal and with the recomment orders.	glists, from the previous 30-day ide any documented rapy (PT) discharge 3/7/16, indicated R28 was to om the dining room with staff on 11/7/16, at 12:52 p.m. R28 om the dining room; R28 was ambulated from the meal with 11/7/16, at 12:55 p.m. R28 ew girls that walk me o walk more so I'm not sitting all and from the dining room for was not walked in accordance indation from the PT discharge on 11/8/16, at 12:31 p.m. R28 heel himself to and from the foffered to assist him with	F 3	-11	DEFICIENCY)		
		on 11/8/16, at 12:34 p.m. no estructions or sheets were room.					
	director of nursing is a deficiency of o attempting to work	n 11/8/16, at 3:30 p.m. the (DON) stated that "ambulation urs," and the facility was on improving this task. The should be a form inside of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245274	B. WING		 	11/0	09/2016
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT				8	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	The DON stated the was during a busy another time of the During follow up in p.m. the DON consheet nor exercise this time. During observation 11/9/16, at 8:21 a. himself to the dining the dining observation 11/7/16, at approxobserved to be an During observation at 1:04 p.m. R6 was visitors and was not recommended as history of face of the dining observation at 1:04 p.m. R6 was visitors and was not recommended as history of face of the wast of the walk meals and activities assist of one to two always walk full distribution of the seven of the se	document exercise activity. nat walking to and from meals time of day, and consequently day may work better. Interview on 11/8/16, at 4:02 firmed there was not a walking eigheet located in R28's room at an of the breakfast meal on m. R28 was observed to wheeling room. In of the breakfast meal on imately 8:30 a.m. R6 was not abulated to the morning meal. In of the noon meal on 11/7/16, as wheeled back to the room by on offered by staff to ambulate. In cated in the medical recording an artificial right shoulder, as	F3	311			

AND DUAN OF CORRECTION IN INDENTIFICATION NUMBER:	(2) MULTIPLE CONSTRUCTION . BUILDING	(X3) DATE SURVEY COMPLETED	
245274 B.	. WING	11/09/2016	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION	
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).	F 311		

	FOF DEFICIENCIES OF CORRECTION							
		245274	B. WING _		11	/09/2016		
	MAYO CLINIC HEALTH SYSTEM - FAIRMONT SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CO 800 MEDICAL CENTER DRIVE, PO E FAIRMONT, MN 56031		DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 311	4/12/16, identified the assistance with his during transitions. Included medication use of a walker and occasional urinary hearing; Proceed the level of functioning R15's care plan revambulated independence of one with a walker longer distances in R15 was listed on the walking list instruct to/from meals follow hallway. R15's daily 30-day period did rewalks. When interviewed stated he transfers his wheelchair for loco On 11/8/16, at 11:4 propelling self down dining room for lund During interview or stated R15 ambula assist on the eveni	vities of daily living (ADL) dated driggers due to needing cares, and balance issues. Additional risk factors in, history of falls, diagnosis, di wheelchair for locomotion, incontinence and decreased to care plan to maintain current ovised 10/4/16, indicated R15 indently to needing supervision or and used a wheelchair for dependently. The daily walking list. The daily ed caregivers to ambulate R15 wing with wheelchair or in any walking list, from the previous not include any documented on 11/7/16, at 12:42 p.m. R15 self from his recliner chair to further indicated he uses his motion. 8 a.m. R15 was observed in hallway in his wheelchair to ch. 11/9/16, at 11:43 a.m. NA-G tes with a walker and one	F 31					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11.	/09/2016
	SOVIDER OR SUPPLIER NIC HEALTH SYSTEM - FAIRMONT STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 311	nursing ambulation R8 R8's face sheet loc dated 11/9/16, iden ankylosing spondyl inflammation of the affect gait and mob R8's most current of dated 8/11/16, iden assistance of one swalking in the corrie BIMS score of 13 (consistency of the affect gait and mob R8's CAA related to R8 triggered due to activities of daily living issues during transfor decline in ADL's with arm weakness wheelchair for locoto avoid complication R8's care plan last R8 had limited physweakness, and was three to four times R8's nursing progration of the times this every on 10/28/16, R8 was walked once in the distance was charted documented to amilione assist. No distance assist. No distance assist. No distance assist. No distance was charted once assist.	ated in the medical record tified current diagnoses of itis of the spine (arthritic joints of the spine which can ility) and osteoarthrosis. quarterly MDS assessment tified R8 required limited staff person for transfers and dor. The MDS also identified a cognitively intact). ADL's dated 3/8/16, identified a needing assistance with his ing, and having balance itions. Additional risk factors include a spinal cord injury, use of a walker and a motion; Proceed to care plan ons. revised on 10/08/16 indicted sical mobility related to se to walk around the square	F 31			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245274	B. WING		11	/09/2016		
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP C 800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031	ODE	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 311	with the nursing as distance was char During observation was observed sea cards with a visitor. During a continuous 3:49 p.m. until 5:5 lobby playing dice R8 was not observalking a walk. During interview o indicated R8 shou day. NA-A stated charted on a shee which was blank for time (4:50 p.m.). During interview o and NA-B indicate times per day, whi walking list and tra RN-B at some point During interview o stated he had not During interview o confirmed R8 shou day, and the result walking sheets.	ed to have ambulated twice ssistant in the hallways. No ted. n on 11/8/16, at 1:03 p.m. R8 ted in his wheelchair, playing	F 31					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11/	09/2016
	NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314 SS=D	walking sheets provopportunities, or an daily. The walking ambulate four times 200 feet with assist. During further intenthe DON indicated computer system, a be documented in the stating there currently of documenting amount of the DON confirmed ambulate residents plan. The facility policy, explain the policy of the facility policy, explain the policy of the facility policy, explain the policy of the facility of function and indeal the facility of the facility who enters the faci	omitted. Of the ten days of vided, R8 only walked 15 of 30 average of once or twice sheets indicated R8 was to a daily with a wheeled walker ance of one staff. view on 11/9/16, at 11:15 a.m. the walks were not put into the although sometimes they might he nursing progress notes, thy was not really a good way bulation at this point in time. It was expected staff would in accordance with the care entitled Rehabilitative and m, dated 11/8/16 indicated cted toward conservation of a restoration of optimal levels expendence, adaptation to an dispersion of deterioration, of disability. ENT/SVCS TO RESSURE SORES orehensive assessment of a remust ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and a healing, prevent infection and	F 3 ⁻¹			12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11/(09/2016	
NAME OF I	PROVIDER OR SUPPLIEF	l		STREET ADDRESS, CITY, STATE, ZII			
мауо с	LINIC HEALTH SYST	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, F FAIRMONT, MN 56031	O BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	by: Based on observareview the facility of promote healing of 1 resident (R8) review the facility of promote healing of 1 resident (R8) review that the control of the cont	eNT is not met as evidenced ation, interview and document failed to provide services to f a pressure ulcer (PU) for 1 of viewed who experienced a pressure ulcer (defined as a poss of skin with exposed and bed that is viable, pink or any also present as an intact or ed blister). quarterly Minimum Data Set and the dated 8/11/16, identified R8 ressure ulcers. The MDS also also atterview for Mental Status and (cognitively intact). sessment (CAA) for pressure identified R8 had risk factors and required a special seat or relieve pressure, was antinent, had altered mental istory of PU; proceed to care	F 31	The Braden scale is comadmission, significant characterity for all residents. used to assess residents for developing pressure unterventions for preventional ulcers will be initiated as it the Braden scale score. Replan has been updated for him to reposition self in which wave of need to remind reposition himself through while in w/c. A new w/c cuphysical therapy was provesident. Pressure Ulcer Policy was nurses to reiterate proper residents that have press at risk for pressure ulcers Audits will be completed as 2; every other week times 2 and quarterly times 3 and quarterly times 4 and 4 and 5	ange and This will be that are at risk alcers. on of pressure indicated from desident s care or staff to remind a/c. Staff are resident to nout the day ushion per vided for s reviewed with r protocol for aure ulcers or are s. every week times a 2; monthly es 2 to monitor sure Ulcer designee.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		245274	B. WING		1	1/09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	diagnoses of ankylo (arthritic inflammati which can affect gaincontinence. R8's most current E assessment tool us development of preindicated a total scoof points should haw was indicated as a points) which indicated as a points) which indicated as a points which interessure ulcer deversible. R8's wound docum time period of 3/10/R8 initially started word cm hardened, red a which intermittently with the most recer on 10/23/16, indicated 60% eschar (brown 20% granulation (no f a darker red color a wound bed during tissue (light pink conduring the wound hardened 1.2 cention A physical therapy (7/19/16 indicated R1 laceration to the right benefit from unweigd during the day, as wound covered. The	ted 11/9/16 identified current using spondylitis of the spine on of the joints of the spine it and mobility) and urinary Braden scale score (an used to identify risk for ussure ulcers) dated 10/28/16, oring of 24 (maximum number ove be 23, friction risk score 4 out of a possible of only 3 ated R8 was not at risk for elopment. The entation flow sheets for the clopment of the right buttocks healed over and re-opened at measurements documented the da wound bed which was nor black, non-viable tissue), ew connective tissue, usually or that forms on the surface of ghealing) and 20% epithelial lored tissue which forms ealing process), which was meters (cm) in size by 1.0 cm. (PT) progress note, dated the upper buttock and would ghting this area intermittently well as to keep the area clean PT progress note did not ment of the wheelchair	F3	14		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11	/09/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	registered nurse (II PU located on the present since 3/10 During observation 12:46 p.m. R8 state his bottom. R8 state once or twice a dain and out of the webathroom. R8 state wheelchair. R8 was vinyl style seat custous experience some of wound area while R8 indicated he discound area was abserved R8's PU bathroom, was abserved a foam discound area was observed a foam discound area was observed a very small slit in flaking skin. LPN-A redness as 4 cm x wound, LPN-A appthe ulcer. LPN-A i wheelchair cushion	age 26 In 11/6/16, at 2:02 p.m. In RN)-A indicated R8 had a stage eright buttock that had been /16, which was recurrent. In and interview on 11/7/16, at ed he had a "pimple area" on atted the staff repositioned him y, and he could transfer himself heelchair to go to the red he had a cushion in his as seated on a blue colored, which are at a stated he did discomfort on his buttock to the ying in bed at night. However, do not have pain in the wound ock while seated in the In with the surveyor on 11/7/16, and practical nurse (LPN)-A are R8 wheeled himself into his eright to stand up, hold onto the eright and to remain standing and ressing from R8's buttocks, ocks with normal saline and removed her gloves, cleansed cated R8 had a stage II atted on the right buttock. Sid not contain eschar. The did not contain eschar are a with form. After measuring the ondicated R8 had the current of for quite awhile and was different cushion had been	F 3	14		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245274	B. WING			11/0	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		8	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	tried/reassessed sin During observation was seated in his w lobby. R8 demonst signs of discomfort During continuous of 3:49 to 5:56 p.m., F his wheelchair and significant changes No staff were observeight during the of the stood up times daily when he and did not otherwing reminders from state seated. R8 indicate never been evaluated development of the "they sure could!" During interview on assistant (NA)-A incomposition of the with transfers in his routine repositioning. During interview on and NA-C indicated skin concerns for R repositioned himse reminded to reposit to walk him several During interview on and NA-C indicated skin concerns for R repositioned himse reminded to reposit to walk him several During interview on and puring interview on the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk him several development of the skin concerns for R repositioned himse reminded to reposit to walk himse reminded to reposit to w	on 11/8/16, at 1:03 p.m. R8 theelchair, playing cards in the trated no verbal/non-verbal observations on 11/8/16, from 8 was noted to be seated in was not observed to make in his position independently. The tweether twe	F3	:14			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245274	B. WING		11	/09/2016	
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F 314	bottom. NA-D was stated R8 did not he program while in the When interviewed (MDS Coordinator) several times per concern he was cabumping them into she was unaware of since the developm. During observation buttock ulcer was of confirmed: the area of 4 cm x 5 cm in the center with sthe wound base, worm. When interviewed director of nursing R8 usually moved chair and so staff or reposition. The DO reassessed R8's a adequately in the wollder developed. The Do a location [on the bound wheelchair and was changes in his when the facility policy, of Management, date ulcers were assess of treatment, with each of the content of the cont	did have a wound on his present also at this time and lave any specific repositioning he wheelchair. on 11/9/16, at 8:35 a.m. RN-B indicated R8 was to walk lay. RN-B stated R8 had been with wheelchair due to the lusing trauma to his ankles, the wheels. RN-B confirmed of any seat cushion changes then of R8's buttock ulcer. on 11/9/16, at 12:25 p.m. R8's beserved with RN-A, who have a stage II PU, the total mof redness had an open slit hiny red tissue extending to hich measured 0.8 cm by 1 on 11/9/16, at 11:17 a.m. the (DON) indicated she thought himself around enough in his were not encouraging him to DN indicated they had not bility to reposition himself wheelchair since the PU ON thought the area was not in outtock] R8 sat on, while in the sinaware of any recent	F 31	4			

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F 314	Skin Integrity, date be assessed for ris alteration. Nursing interdisciplinary pla altered skin integrit policy did not addre for pressure ulcers weekly wound doct 483.25(I) DRUG RI UNNECESSARY Exact resident's druunnecessary drugs drug when used in duplicate therapy); without adequate nindications for its u adverse conseques should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs as diagnosed and record; and resider drugs receive grad behavioral intervents.	entitled Integumentary System: d 11/9/16 indicated patients will sk of developing a skin will develop an individualized, an of care for prevention of ty on hospitalized patients. The ess other preventive measures beyond skin assessments and umentation. EGIMEN IS FREE FROM DRUGS ag regimen must be free from a c. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F3			12/8/16	

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	PROVIDER OR SUPPLIER LINIC HEALTH SYSTE	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 80 FAIRMONT, MN 56031	-		
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F 329	Continued From pa	ge 30	F 32	9			
	by: Based on interview facility failed to evalued identify parameters (PRN) pain medical Tramadol) for 1 of Sunnecessary medicobservation, interviewed in medications for reviewed with pain. Findings include: R23 was admitted and chronic pain syndrof fracture per care plus R23's signed physic included orders for milligrams (mg) 2 to PRN pain or fever a every six hours PRI The quarterly Minimassessment dated having a Brief Intervof 14 indicating inta PRN and non-medi Pain assessment ir identifies R23 as have on 1-10 pain scale. Review of R23's cala goal indicating R2	cian orders dated 9/12/16, acetaminophen tablet 500 ablets by mouth every 6 hours and Tramadol 50 mg by mouth N pain control. num Data Set (MDS) 9/7/16, identified R23 as view for Mental Status (BIMS) act cognition, and receiving cation interventions for pain. Interview in the MDS further aving frequent pain rating it a 7		Parameter orders were received two pain medications that resident uses. Resident 53 has been discharged the facility. All residents will be assessed for parameters with 30 dareviews by the consulting pharmat Resident is pain medications have updated to include parameters for Pain Management Policy was reviwith nurses. PRN medications mulinclude follow-up charting to deter effectiveness of medication. Pain parameters will be asked for with parameters will be asked for with parameters will be completed every we times 2, every other week times 2, times 2 and quarterly times 2 to mand use of parameters with medication orders. Done by DON or designed Results of audits will be presented QA committee.	from pain y drug cist. e been use. ewed st mine level pain ek monthly onitor llow up ation e.		

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F 329	side effects of pain pain characteristics nurse any signs or monitor/record/reporefusal to eat and with Review of R23's mark (MAR) for October the following: - R23's MAR dated received 9 doses of PRN Trandiscomfort. R23's lused to monitor PR administered medication for esult from PRN administered medication had been received 9 doses of PRN Trandiscomfort. R23's lused to monitor PR administered medication for esult from PRN medication had been result from PRN medication had been received 9 doses of PRN administration for medications had been received 9 doses of PRN administration of Tracetaminophen on 11/2/16.	staff to monitor/document for medication, monitor /record PRN, Monitor/record/report to symptoms of non-verbal pain, ort to nurse loss of appetite, weight loss. edication administration record and November 2016 identified and Identified All Identified	F 3	29		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 329	medication aide (Trequests a PRN mecharge nurse, and medications were redirected by the charton administer. At 1 (RN)-C stated "its apain is rated less this given and higher medication. RN-C to be documented assessed for effect. During interview on verified PRN medication notes. RN-C also oparameters identificated acetaminophen vs. During interview on indicated it is a nurpain medication to indicated there was the board unless sphysician. During interview on of nursing (DON) cadminsitration of Pparameters for ace and verified the lace for effectiveness on The DON stated he the medical doctors parameter, however	MA)-A stated if a resident edication, she notifies the further stated PRN not given by TMA's unless rge nurse on what medication 1:42 a.m. registered nurse a nursing judgment call"; if the nan 5 (pain scale 1-10) Tylenol than 5 give the stronger further indicated PRN's were on medication note form and iveness. 1 11/8/16 at 4:34 p.m. RN-C cations were not consistently evaluated for effectiveness one form nor in nursing progress confirmed there were no ed related to administration of		29			

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F 329	consultant pharma pain medications to and expect staff to medications after on the staff to a st	n 11/9/16, at 1:24 p.m. cist indicated she would expect be clarified with a parameter review effectiveness of pain given them. dated 11/8/16 identified current stage renal disease and a femoral neck and an admission ata Set (MDS) assessment and ments (CAA) were in progress	F3	329			
	muscle spasms, co	ontinue to work with PT, up and walk often. Order for					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	(XX	B) DATE SURVEY COMPLETED	
		245274	B. WING			11/09/2016	
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F 329	Flexeril 5 mg po for spasms. R53's medication s R53 had taken the since it was ordere receiving the oxyco on average four time received. The Lutz Wing Pair which included document medication and/or a occasions. Pain le 5-7 (10 point rating or assessment of the medication was additional medication was better the wished his pain leving he last received ox morning. No non-visualized at this timburing observation 12:30 p.m. R53 was bed, eating lunch, bad right now, rating facial grimacing and his thigh and had jupain. R53 also stating muscle spasming and his muscle spasming muscle spasming muscle spasming muscle spasming medication spanning medicat	cheets dated 11/16, indicated Flexeril a total of ten times d on 11/3/16, and had been odone 5 mg on 28 occasions, nes/day since the order was an Progress notes, dated 11/16 elumentation for pain levels with N) pain medications only ration of the reason for the pain a pain rating recorded on 12 vels were listed ranging from g scale). No follow up response the pain level after the ministered was documented. and on 11/7/16, at 12:29 p.m. his room and indicated he had (10 point scale) in his left leg, nan yesterday. However, R53 el could be a zero and stated ycodone at 6:00 a.m. that verbal signs of pain were		329			

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		245274	B. WING		 	11/0	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		8	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	on the left thigh at the During interview on stated he had just have having pain in (10 point scale). During interview on registered nurse (Ralways accepting or been somewhat de staff asked him about medication pass an assistants (TMA) states and significant degree of treatments, stating comfortable." RN-Edue to his recent or During interview on practical nurse (LPI R53's pain level wit R53 had tried hot a hip. LPN-B indicate offer R53 the Flexe scheduled basis to pain, which had incomedication, but also medication, but also medication, but also medication, but also states and puring interview on it was verified that scharting pain levels medication, but also	his time. 11/6/16, at 6:50 p.m. R53 had a left hip replacement and his left leg, which he rated a 7 11/7/16, at 1:36 p.m. N)-D stated R53 was not f pain medications and had pressed lately. RN-D stated but his pain level with each had the trained medication aff should be doing so also. 11/8/16, at 12:41 p.m. RN-Ed balance had been stable she had not noticed a high pain during his dialysis R53 appeared "fairly felt most of R53's pain was thopedic surgery. 11/8/16, at 1:09 p.m. licensed N)-B stated she monitored him medication passes and that and cold packs today for the left fed nursing staff were trying to ril 3 times/day on a more see whether this helped his reased the last couple of days. 11/8/16, at 3:25 p.m. the DON staff should not only be when they give the pain of the follow up response to the in the PRN medication flow	F3	29			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	` '	E SURVEY IPLETED
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F 329 F 334 SS=E	consultant pharmace be evaluating effect an hour or so after effectiveness and to the facility policy, edated 7/2/14 indicated accepted as the miccurrent level of pair intensity scale was For long term care reassessment shour interventions, with a report of pain, exact discharge or transform the policy further stimely manner account ones for the intervention. 1. **Moderate of the intervention of the in	a 11/9/16, at 1:22 p.m. the cist (CP) indicated staff should tiveness of pain medications giving them, to monitor for his should be documented. Intitled Pain Management, ted the patient's self-report is cost accurate measure of the m. A zero to ten numeric pain listed as an acceptable tool. settings, the policy indicated ald occur after pain a change in condition, a new cerbation of pain and at er to another level of care. Itated this should be done in a cording to the expected atervention (e.g. efficacy of an expected policies and procedures the influenza immunization,	F 32	29		12/8/16
	immunization Octol annually, unless the contraindicated or t immunized during t (iii) The resident or	offered an influenza ber 1 through March 31 e immunization is medically the resident has already been his time period; the resident's legal the opportunity to refuse				

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	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 334	documentation that following: (A) That the resid representative was the benefits and poimmunization; and (B) That the resid influenza immunization influenza immunization contraindications of the facility must detat ensure that (i) Before offering the immunization, each legal representative the benefits and poimmunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unle medically contrained already been immunication; and (iv) The resident or representative has immunization; and (iv) The resident's documentation that following: (A) That the resid representative was the benefits and popneumococcal immunication; and (B) That the resid pneumococcal immunication immunication coccal immuni	medical record includes t indicates, at a minimum, the ent or resident's legal provided education regarding otential side effects of influenza ent either received the ation or did not receive the ation due to medical r refusal. evelop policies and procedures the pneumococcal r resident, or the resident's receives education regarding otential side effects of the soffered a pneumococcal ss the immunization is dicated or the resident has unized; the resident's legal the opportunity to refuse medical record includes t indicated, at a minimum, the ent or resident's legal provided education regarding otential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical	F 33	4		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245274	B. WING		11/0	9/2016	
	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 334	and practitioner re- pneumococcal imr years following the immunization, unle	re, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ass medically contraindicated or resident's legal representative	F 334				
	by: Based on interview facility failed to improcedure related vaccine (PCV13) a by the Centers for 23 residents (R5, R30 and R34) who received and who practioner following dated 09/22/16. Findings include: R5's vaccination redate of 5/20/13, ar Valent) on 5/10/12 Immunization infor R5 was seen by th 10/18/16 and there vaccination status PVC13 vaccination red	ecord indicated an admission		Residents have received pneumon needed per CDC recommendations for pneumon have been reviewed with nurses. Now will check residents immunization records upon admission and ask providers for orders for immunization that are deemed necessary. Audits will be completed after each admission for 3 months to ensure the immunizations have been completed CDC recommendation. Done by DC designee. Results of audits will be presented to the QA committee.	s. povax lurses n pons hat the ed per		
	10/1/07 per MICC	d received the 23 Valent on system. R7 was seen by the on 10/4/16, yet there was no					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245274	B. WING		11	/09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CO 800 MEDICAL CENTER DRIVE, PO B FAIRMONT, MN 56031	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	indication the vacci reviewed nor the PNR15's vaccination redate of 5/7/12 and redate of 5/7/12 and redate of 4/8/11 and redate of 4/8/11 and redate of 4/8/11 and redate of 4/8/11 and redate of 1/7/16. Although Redate of 1/7/16, however the process of 1/7/16, however the process of 1/7/16 and redate of 1/7/16 and redate of 1/7/16 and redate of 1/7/16 and redate of 6/20/14 with 6/9/14. The most redate of 6/27/14 with 12/15/99. The most visit was dated 9/30 was lacking indication.	nation status had been VC13 vaccination offered. ecord indicated an admission receipt of the 23 Valent on the medical practioner on ation was lacking to indicate tion had been offered. record indicated an admission received the 23 Valent on 19 was seen by the medical 16, and there was no adicate the PVC13 was ecord indicated R23 had an always as well and received the 23 R23 saw the medical practioner ver, no PVC13 was not offered. ecord indicated an admission the most recent medical dated 10/4/16; there was no	F 3	34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245274	B. WING		11.	/09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BO) FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 334	on 10/16/06. R34 medical practitione was lacking to indicoffered. The CDC recommed years of age or oldereceived PCV13 arreceived one or modereceived in a mean of the next modereceived one or modereceived one of the next modere	in the 23-Valent administered was most recently seen by the r on 9/27/16; documentation cate the PVC13 had been endations indicated, "Adults 65 er who have not previously and who have previously bre doses of PPSV23 ysaccharide vaccine 23] ose of PCV13. The dose of administered at least one year nt PPSV23 dose." Indicated an email dated of the nursing staff with the link eb site regarding mmendations for the PVC13 dition, an email dated 9/22/16, enursing and medical staff as for review of vaccination g the PVC13 vaccination at the	F 33	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245274	B. WING		11/09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT	8	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 371 SS=E	On 11/08/16, at 12: (RN)-C was intervie aware of the email implementation of t licensed practical n were also in attendathey were aware of detailing the process. The health informatinterviewed on 11/0 indicated the memorprocess in which reevaluated/updated recommendations on nursing home visit. been no process in whether this had be 483.35(i) FOOD PF STORE/PREPARE/	25 p.m. registered nurse wed and indicated he was not memo related to the he PVD process. However, urse (LPN)-B and RN-B who ance at this time, indicated the memo dated 9/22/16 ss. cion coordinator (HIC) was 8/16, at 12:35 p.m. and dated 9/22/16, detailed the sidents would be with the current CDC during either a clinic and/or It was confirmed there had place to implement/monitor ten initiated. COCURE, SERVE - SANITARY	F 334		12/8/16
	by: Based on observat review the facility fa were held or served	NT is not met as evidenced ion, interview and document illed to ensure pureed foods at the proper temperature to liness for 4 of 4 residents		Education has been provided to sta clarify that we must temp food just p serving in order to ensure correct temperature has been held. If neces	rior to

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245274	B. WING	 	11/(09/2016	
	PROVIDER OR SUPPLIER	EM - FAIRMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 371	altered diets. Findings include: During observation 11:54 a.m. dietary athermometer to che food in the steam to serve in the dining were recorded on the steam table are bowls of pureed che reported pureed for checked in the dinithe kitchen and the covered bowls on a table until served. The meals are the last 12:08 p.m. DA-A with pureed food when temperature check biscuit. Upon composerving temperatur Fahrenheit (F) with explained that a sed degrees F was desalready it was warr proceeded to have buring interview or dietary manager (Eto the temperature served into bowls, other steam table for serving temperature recorded once food	age 42 33) who had mechanically of lunch meal on 11/8/16, at aide (DA)-A used a food eck the temperatures of the able she was preparing to room. Food temperatures he Daily Service log and DA-A donto trays. To the left side of ea was a tray with four covered icken and biscuits. DA-A od temperatures are not ng room because it is done in a tray located to side of steam DA-A further stated pureed to be served during dish up. At as ready to serve the bowls of the surveyor requested a of the pureed chicken and oletion, DA-A revealed a e of 110 and 111 degrees in the four bowls. DA-A erving temperature of 140 sired, but since it was cooked in enough to serve, and the meals delivered. of 11/8/16, at 3:23 p.m. the DM) stated after food is cooked of 165 degrees F it is pureed, and delivered on a tray with ood items. No holding nor re checks are routinely d has been pureed. At 4:01 is a safe serving temperature is	F 37	food will be reheated and pl steam table, or holding over temperature prior to transpore NF, food will be placed in the holding area until the food is which time the food will be to A log of all temps will be keymanager, or his designee, to verify. This will be done once the first month, 2x per mont two months and then quarter quarters. Results of audits we presented to the QA commits.	n to maintain ort to NF. At the appropriate is served, at the emped again, not in the NF for the audit and the per week for the nextherly for 2 will be		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BO FAIRMONT, MN 56031	E.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371 F 441 SS=D	temperatures of pu (11/8/16) were beld facility needs to ma related to mechaniserving temperature documenting the p An Untitled form pr 8/2009, indicated had temperatures must for above while have commended sempoultry, seafood, ensure hot at point 483.65 INFECTION SPREAD, LINENS The facility must example of the process of the proces	and confirmed that serving breed food at lunch today ow that. The DM verified the take changes in their process cally altered food so that a safe re was ensured, including bureed food temperatures. Tovided by facility, last revised not product holding to be maintained at 140 degrees colding and serving. It further wing temperatures of meat, ggs at 145-165 degrees F to of consumption. N CONTROL, PREVENT Stablish and maintain an rogram designed to provide a comfortable environment and development and transmission	F 37			12/8/16
	(a) Infection Control The facility must exprogram under wh (1) Investigates, coin the facility; (2) Decides what p should be applied to (3) Maintains a recoactions related to in (b) Preventing Spro (1) When the Infective determines that a recommendation.	ol Program stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections.				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED				
		245274	B. WING _		11/09/2016			
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTI	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031)DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉTION			
F 441	communicable dise from direct contact direct contact will tr (3) The facility mus hands after each dihand washing is inc professional practic (c) Linens Personnel must ha transport linens so infection.	t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted	F 44	11				
	by: Based on observareview, the facility for hygiene had been procares for 1 of 1 resimorning cares. Findings include: R28's quarterly Minassessment dated extensive assistant and limited assistant one staff member. was frequently inconcurring observation nursing assistant (Not completing morning observed to don globathroom, wash R2	tion, interview and document ailed to ensure proper hand performed during personal ident (R28) observed during simum Data Set (MDS) 8/3/16, indicated required be for dressing and toileting face with personal hygiene of The MDS also identified R28		Education was provided to CNA during the survey. Nursing staff completed a compregarding donning and doffing ghand washing during 2016. Star Precautions Policy was reviewed nursing staff. Audits will continue to be donewashing audits each month to monitic compliance with policy. Done by designee. Results of audits will presented to the QA committee.	petency floves and ndard d with 5 hand 5 glove or DON or be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		(X3) DATE SURVEY COMPLETED	
		245274	B. WING		11/09/2016	
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031		
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F 441	R28's bottom, put of and then comb R28 same pair of gloves NA-E proceeded to channel while still v During interview on confirmed she did wash her hands aft proceeding to finish objects such as the During interview on director of nursing be removing their goares when they be hands before comporares. The DON in to audit handwashi The facility policy, e Policy, dated 11/9/17 removed, discarder after hand hygiene contaminated, used torn and punctured 483.70(h)(1) PROC WATER AVAILABIL	NA-E proceeded to wash on a clean pad, pants and shirt as hair, while still wearing the se. Without washing her hands, a change R28's television wearing the soiled gloves. In 11/9/16, at 7:38 a.m. NA-E not change her gloves and er cleansing R28's bottom and in his dressing and touch other extelevision in his room. In 11/9/16, at 12:56 p.m. the (DON) confirmed staff should gloves after providing personal excome soiled and wash their oleting the remainder of the indicated they had been trying ing on a monthly basis. In titled Standard Precautions is completed, if gloves are defrom dirty to a clean area or completed. If gloves are defrom dirty to a clean area or calcally a constant of the stablish procedures to ensure to be to essential areas when	F 44		12/8/16	
	by:	NT is not met as evidenced v and document review the		Procedures to ensure water availab	pility -	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` '	E SURVEY PLETED
		245274	B. WING _		11/0	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIF 800 MEDICAL CENTER DRIVE, P FAIRMONT, MN 56031	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 466	for the emergency specified the amou water, a method fo water required and This has the potent who reside in the facility had a memergency water swater. The DON in check with facilities On 11/8/16, at 6:12 memo of understar Fairmont for the prwater which indicate gallons per day permethod of distribut understanding was An additional Facility Potable Water, cop Foundation for Medwhich was unsigned Trucking would promethod of distribut understanding was Union for Medwhich was unsigned Trucking would promethod of distribut During further interthe DON stated the emergency water in the method for calcumethod of distribut During further interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water interthe DON stated the emergency water in the method for water in the method f	sure it had a current procedure provision of water which ant of potable and non-potable r calculating the amounts of the method of distribution. tial to affect the 24 residents acility. The conference on 11/6/16, at tor of nursing (DON) indicated emo of understanding for its supply with Culligan for potable adicated she would need to a management to get a copy. The person culligan Water of ovision of emergency potable and a needed rate of two reperson, but did not specify a ion. The memo of adated 11/8/16. The memo of Understanding for oviging the 2011 by Mayo dical Education and Research and, indicated Viessman ovide clean potable water to System in Fairmont but lacked lating the amount and the	F 46	Water Supply Policy for M was update in November have been updated, and s received. Facilities Manag will be responsible for this will be given to QA commic completion.	of 2016. Policies signatures per or designee task. Update	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DA ⁻ COI	(X3) DATE SURVEY COMPLETED	
		245274	B. WING		11	/09/2016	
	ROVIDER OR SUPPLIER	EM - FAIRMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	

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PRINTED: 12/09/2016 FORM APPROVED OMB NO. 0938-0391

	NAME OF CORDECTION INCLUDING A STOLEN WINDER		15.	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245274	B, WING	/	11	/09/2016
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT			STREET ADDRESS, CITY, STATE, ZIP CO 800 MEDICAL CENTER DRIVE, PO I FAIRMONT, MN 56031	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST MS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.				
	Minnesota Departr Fire Marshal Division Mayo Clinic Health not to be in substated requirements for polymerical Medicare/Medicaid 483.70(a), Life Satedition of National	d at 42 CFR, Subpart fety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	OR THE FIRE SAFETY		FPO	C	

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.

	13 I ON WILDIOMN	E & MEDICAID SERVICES			ONID NO	. 0938-039
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG 01 - Main Building 01		TE SURVEY MPLETED
		245274	B. WING		11	/09/2016
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT				STREET ADDRESS, CITY, STATE, ZIP 800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
K 000	Angela.Kappenma <mailto:angela.ka 1.="" 1990="" 2.="" 3.="" a="" actual,="" and="" as="" basement,="" buildi="" building="" clinic="" co="" const="" constructed="" construction.="" correct="" corridors="" defic="" deficiency="" description="" detection="" determine="" facility="" fol="" following="" for="" has="" healt="" i(332)="" in="" inf="" is<="" mayo="" mu="" name="" of="" one-story,="" or="" original="" p="" partial="" plan="" prevent="" protected="" reoccur="" responsible="" sprinkler="" td="" the="" to="" type="" was="" which=""><td>state.mn.us hitney@state.mn.us> and an@state.mn.us appenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person wrection and monitoring to rence of the deficiency. h System Fairmont was lows: ng was constructed in 1972, is partial basement, is fully fire d and was determined to be of</td><td></td><td></td><td></td><td></td></mailto:angela.ka>	state.mn.us hitney@state.mn.us> and an@state.mn.us appenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person wrection and monitoring to rence of the deficiency. h System Fairmont was lows: ng was constructed in 1972, is partial basement, is fully fire d and was determined to be of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			I ` '	PLE CONSTRUCTION 3 01 - MAIN BUILDING 01		E SURVEY PLETED
		245274	B. WING	y	11/0	09/2016
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031	800		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 341 SS=F	Fire Alarm System A fire alarm system components approaccordance with I and NFPA 72, Na provide effective building. In areas detection is install unit. In new occupant notification appand supervising s	m is installed with systems and loved for the purpose in NFPA 70, National Electric Code, tional Fire Alarm Code to warning of fire in any part of the not continuously occupied, led at each fire alarm control pancy, detection is also installed pliance circuit power extenders, station transmitting equipment. In wiring or other transmission red for integrity.	K 34			12/8/16
	Based on observe failed to maintain accordance with Code, and NFPA Code. This deficie 25 residents. Fire Alarm System A fire alarm system components approaccordance with Code, and NFPA provide effective building. In areas detection is install unit. In new occupant notification approand supervising states.	em is installed with systems and roved for the purpose in NFPA 70, National Electric 72, National Fire Alarm Code to warning of fire in any part of the not continuously occupied, led at each fire alarm control pancy, detection is also installed bliance circuit power extenders, station transmitting equipment. In wiring or other transmission red for integrity.		During the survey on 11/9/16 it that the annunciator on the 2nd not working. Fire alarm annunciat the 2nd floor nurses station is properly. This panel functions an illuminates the alarm and location during an alarm. Thus, when not the screen comes up blank. Fact Manager or designee is responsible updating literature to notify staff committee will be notified at our meeting.	floor was ator panel s working and on ONLY in alarm, cilities sible for . QA	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245274	B. WING			11/09/2016	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT			80	REET ADDRESS, CITY, STATE, ZIP CODE 00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 341	Continued From pa	age 3	K	341			
K 354 SS=F	on 11/09/2016, obson the Fire Alarm A Floor Nurses Static This deficient pract Maintenance Direct NFPA 101 Sprinkler System - Where the sprinkle extent and duration determined, areas inspected and risk recommendations or designated reprodepartment and ot jurisdiction have be sprinkler system is hours in a 24-hour of the building affe approved fire watch system has been in 18.3.5.1, 19.3.5.1, This STANDARD Based on docume the Facility failed to accurate Fire Sprinkler System - Where the sprinkle extent and duration	ween 11:00 AM and 3:00 PM servation revealed the screen annunciator Panel at the 2nd on appeared not to functioning. Since was verified by the Facility tor. To System - Out of Service Out of Service To system is impaired, the most the impairment has been or buildings involved are are determined, are submitted to management esentative, and the fire ther authorities having the notified. Where the out of service for more than 10 period, the building or portion cted are evacuated or an his provided until the sprinkler eturned to service. 9.7.5, 15.5.2 (NFPA 25) is not met as evidenced by: entation review and interview, or provide a current and other out of Service Policy. The sould affect 25 out of 25		354	Life Safety System Failure and Fir Watch program Procedure is upda The new policy will be submitted to committee at our next meeting. Fa Manager or designee is responsib this task.	ated. o the QA acilities	12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY	
		245274	B. WING			11/0	9/2016	
	NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 354	or designated reprodepartment and off jurisdiction have be sprinkler system is 10 hours in a 24-ho portion of the build an approved fire w sprinkler system had 18.3.5.1, 19.3.5.1, FINDINGS INCLUI On facility tour betwon 11/09/2016, doc that the Out of Ser Sprinkler System of contact information time needs to be under the out of Ser Sprinkler System of contact information time needs to be under the out of Ser Sprinkler System of contact information time needs to be under the out of Ser Sprinkler System of contact information time needs to be under the out of Ser Sprinkler System of contact information time needs to be under the out of Ser Sprinkler System of contact information time needs to be under the output of the output of the output of the plan is operator or with their copy of the plan is operator or with sepasic response recomponents per 18.7.1.1 through 18.7.2.3, 19.7.1.1 through 18.7.2.3, 19.7.1.1 through 1.1.1 throug	are submitted to management esentative, and the fire her authorities having sen notified. Where the out of service for more than our period, the building or ing affected are evacuated or atch is provided until the as been returned to service. 9.7.5, 15.5.2 (NFPA 25) DE: Ween 11:00 AM and 3:00 PM cumentation review revealed vice Policy for the Fire does not have current staff and the 10 hour out of service pdated. Itice was verified by the Facility stor. Ition and Relocation Plan plan for the protection of all eir evacuation in the event of a readily available with telephone curity. The plan addresses the quired of staff per 18/19.7.2.1.2 of the fire safety plan 8/19.2.2. 8.7.1.3, 18.7.2.1.2, 18.7.2.2, through 19.7.1.3, 19.7.2.1.2, through 19	K	711			12/8/16	
		is not met as evidenced by: entation review and interview,			During the survey on 11/9/16 it was	s noted		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	L ` ′		STRUCTION AIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245274	B. WING			11/0	9/2016	
	PROVIDER OR SUPPLIER			800 ME	ADDRESS, CITY, STATE, ZIP CODE DICAL CENTER DRIVE, PO BOX 8 ONT, MN 56031	300		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 711	the Facility failed to Relocation Plan ac Code. This deficien 25 residents Evacuation and Re There is a written patients and for the an emergency. Employees are peinformed with their copy of the plan is telephone operato addresses the bas per 18/19.7.2.1.2 a safety plan compo 18.7.1.1 through 1	o maintain a Evacuation and according to the 2012 Life Safety at practice could affect 25 of the elocation Plan plan for the protection of all eir evacuation in the event of riodically instructed and kept aduties under the plan, and a readily available with a ror with security. The plan ic response required of staff and provides for all of the fire nents per 18/19.2.2. 8.7.1.3, 18.7.2.1.2, 18.7.2.2, through 19.7.1.3, 19.7.2.1.2,	К7	that nee poli curi of a Mai this	MCHS - Fairmont Fire Safet and to be reviewed and updated to be reviewed and updated to inclurent Fire Marshall's contact in any evacuation emergency. Finager or designee is responsitask. The QA committee will lated at our next meeting regision of the policy.	ited. The de the fo in case acilities ible for be		
K 712 SS=F	on 11/09/2016, do the Emergency Fir ensure all the requestre and t	tice was verified by the Facility otor.	K 7	12			12/8/16	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245274	B. WING _		11/0	9/2016
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
K 712	persons who are Where drills are 6:00 AM, a code instead of audible 18.7.1.4 through 19.7.1.7 This STANDARD Based on docum the Facility failed accordnance with 19.7.1.4 through could affect 25 or Fire Drills Fire drills include signal and simula conditions. Fire of times under vary on each shift. The and is aware that routine. Response who are Where drills are 6:00 AM, a code instead of audible 18.7.1.4 through 19.7.1.7. Findings include: On facility tour be on 11/09/2016, detail a fire drill was shift in the 4th questions.	is assigned only to competent qualified to exercise leadership. Conducted between 9:00 PM and announcement may be used a alarms. 18.7.1.7, 19.7.1.4 through It is not met as evidenced by: nentation review and interview, to conduct Fire Drills in 18.7.1.4 through 18.7.1.7, 19.7.1.7. This deficient practice f 25 residents. The transmission of a fire alarm ation of emergency fire littles are held at unexpected ing conditions, at least quarterly e staff is familiar with procedures the drills are part of established sibility for planning and is assigned only to competent qualified to exercise leadership. Conducted between 9:00 PM and diannouncement may be used e alarms. 18.7.1.7, 19.7.1.4 through etween 11:00 AM and 3:00 PM ocumentation reviewed revealed as not conducted during the night parter (Oct-Dec) 2015.	K 71:	Fire drills are ran each shift, qual Lutz Wing. During further review records during the survey, it show fire drill was missed in 2015. Goir forward, all drills will be measured reported to the site EOC for revier follow up. Facilities Manager or dis responsible for this task. QA Cwill be updated on status of fire dour next meeting.	of our vs one ng d and w and esignee ommittee	
K 918		ical Systems - Essential Electric	K 91	8		12/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		245274	B, WING			11/0	09/2016
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT			800 M	ET ADDRESS, CITY, STATE, ZIP CODE MEDICAL CENTER DRIVE, PO BOX MONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Continued From p Syste	age 7	K	918			
	Maintenance and The generator or cand associated equipolity for the limited process shall be processed in the process shall be processed in the process of the limited processed in the processed	other alternate power source upper alternate power source upper seconds. If the 10-second to during the monthly test, a rovided to annually confirm this fe safety and critical branches. It the generator and are performed in accordance in inspected weekly, exercised utes 12 times a year in 20-40 exercised once every 36 nuous hours. Scheduled test ons include a complete rt and automatic or manual loads, and are conducted by nel. Maintenance and testing of ver sources (Type 3 EES) are in IFPA 111. Main and feeder to inspected annually, and a dically exercising the sablished according to uirements. Written records of testing are maintained and EES electrical panels and d and readily identifiable. Saibility of damage of the source is a design new installations. (NFPA 99), NFPA 110, NFPA		t t	Monthly generator testing is de accordance with regulations se the Joint Commission and Stat Marshal's office. During the su	et forth by te Fire	

PRINTED: 12/09/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	l ` ′	D1 - MAIN BUILDING 01	COMPLETED	
		245274	B. WING		11/09/2016	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
K 918	Electrical Systems Maintenance and The generator or and associated exservice within 10 criterion is not me process shall be process with NFPA 110. Generator sets are under load 30 minday intervals, and months for 4 confunder load conditions simulated cold state transfer of all EES competent person stored energy powaccordance with circuit breakers a program for period components is estimated and readily available. Circuits are marked Minimizing the process manufacturer required in the process of the process o	could affect 25 of 25 residents. s - Essential Electric System Testing other alternate power source quipment is capable of supplying seconds. If the 10-second et during the monthly test, a crovided to annually confirm this ife safety and critical branches. testing of the generator and are performed in accordance re inspected weekly, exercised nutes 12 times a year in 20-40 I exercised once every 36 tinuous hours. Scheduled test ions include a complete art and automatic or manual S loads, and are conducted by nnel. Maintenance and testing of wer sources (Type 3 EES) are in NFPA 111. Main and feeder re inspected annually, and a adically exercising the stablished according to uirements. Written records of I testing are maintained and EES electrical panels and ed and readily identifiable. pssibility of damage of the r source is a design new installations. I (NFPA 99), NFPA 110, NFPA	K 918	noted that we had not included or form the cool down period, and the amount of time the generator propower from the transfer. This has added to our monthly generator I Facilities Manager or designee is responsible for this task.	ne vides s been og.	

Facility ID: 00359

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245274	B. WING _		11	/09/2016
	PROVIDER OR SUPPLIER LINIC HEALTH SYST			STREET ADDRESS, CITY, STATE, ZIP C 800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
K 918	documented during Generator Load Tellong it takes the errower and the amogenerator is run af not being recorded	uired information is being g the Month Emergency est. The transfer time of how mergency generator to assume ount of cool down time the fer the load test is completed is d.	K 91			



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 <u>only a suggestion</u> 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

Mayo Clinic Health System - Fairmont November 28, 2016 Page 2

"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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

Mayo Clinic Health System - Fairmont November 28, 2016 Page 3 Mayo Clinic Health System - Fairmont November 28, 2016 Page 4

PRINTED: 12/09/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00359 11/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 **MAYO CLINIC HEALTH SYSTEM - FAIRMONT** FAIRMONT, MN 56031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/07/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		B. WING			0/00/0
	00359	b. WING		11/0	9/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO CLINIC HEALTH SYSTEM	- FAIRMONI	T, MN 5603	R DRIVE, PO BOX 800 1		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
you electronically. Alti is necessary for State enter the word "correct text. You must then incompletion date, the discorrected prior to elect Minnesota Department. On November 6th, 7th surveyors of this Department of the provider and the orders are issued. Ple electronic plan of corrective wed these orders they will be completed. Minnesota Department the State Licensing Confederal software. Taging assigned to Minnesota Nursing Homes. The assigned tag number column entitled "ID Prostatute/rule out of community statement and replaces the "To Confederal software in value of the statement, "The evidence by." Following are the Suggested Medical Time period for Correct PLEASE DISREGARD FOURTH COLUMN Western to the statement of the statement of the Suggested Medical Time period for Correct PLEASE DISREGARD FOURTH COLUMN Western the statement of the statement of the Suggested Medical Time period for Correct PLEASE DISREGARD FOURTH COLUMN Western the Suggested Medical Time period for Correct PLEASE DISREGARD FOURTH COLUMN Western the State Policy of the statement of	orders being submitted to though no plan of correction estatutes/Rules, please cted" in the box available for dicate in the electronic ass, under the heading date your orders will be ctronically submitting to the following correction ease indicate in your rection that you have as, and identify the date when d. Into of Health is documenting orrection Orders using numbers have been a state statutes/rules for the refix Tag." The state in the of Deficiencies" column Comply" portion of the column also includes the violation of the state statute This Rule is not met as ing the surveyors findings ethod of Correction and ction. Differ HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 GSPL11 If continuation sheet 2 of 45

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00359	B. WING	·····	11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEAR ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			12/8/16
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review the facility fa related to thromboo bleeding/bruising fo	ent is not met as evidenced on, interview and document alled to develop a care plan sytopenia and risk for or 1 of 3 residents (R15) ressure related skin conditions.		Corrected.		
	Findings include:					
	diagnosis of thromb platelets in the bloo	agnosis report included pocytopenia (deficiency of d that causes bleeding into g, and slow blood clotting after				
		p.m. R15 was observed to d dark purple bruises with ng around the area				

Minnesota Department of Health

STATE FORM 6899 GSPL11 If continuation sheet 3 of 45

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	MAYO CLINIC HEALTH SYSTEM - FAIRMONT 800 MED FAIRMO			R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 560	approximately 3 ce During interview wis stated he obtained through door ways, hand. On 11/9/16, bruise easy". Review of R15's plincluded an order foused to suppress theffect of increased milligrams (MG) by platelets (parts in the clot) and an order prednisone to 7.5 MR eview of R15's lated 10/31/16 indicate with the clot of the	ntimeters (cm) in diameter. th resident at this time, he the bruises when going reaching and bumping right at 11:38 a.m. R15 stated "I hysician orders dated 9/27/16 or prednisone (a medication ne immune system with side bruising tenancy) 10 mouth in the morning for low ne blood that help the blood on 10/17/16 to decrease MG daily. Doratory results from 9/6/16 to reekly platelet levels were elet results ranged from liter (L) with normal reference 50,000 platelets per L. sated call from laboratory platelet counts of 26,000 per L are plan, revised 10/4/16, eing at risk for pressure ulcers eluding previous pressure nedications, use of a	2 560			
	registered nurse (R diagnosis of thromb	IN)-B indicated R15 has had a cocytopenia for over a year ted with prednisone. Further				

Minnesota Department of Health

STATE FORM GSPL11 If continuation sheet 4 of 45

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00359	B. WING		11/0	0/2016
NAME OF I				TATE 7/D CODE	11/0	9/2016
	PROVIDER OR SUPPLIER	800 MEDI	, ,	STATE, ZIP CODE R DRIVE, PO BOX 800		
MAYO CI	LINIC HEALTH SYSTE	-M - FAIRMONI	T, MN 5603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ige 4	2 560			
	levels. RN-B verifie interventions relate bleeding/bruising, s there".	stating "that should've been in				
	of nursing (DON) st care plan is develop	11/9/16, at 12:50 p.m. director tated her expectation is that a ped when someone has a d risks of bleeding/bruising.				
	dated 4/5/16, indica assists in developin each resident that it the resident and the each problem/need Care Conferences care plan compone problem/need/stren with target date, intidisciplines involved	Care Conferences Procedure- ated care conference day RN ag a written plan of care for dentifies the problems/need of e goals to be accomplished for lidentified. Facility policy titled Policy- dated 4/5/16 indicated ants include: agth statement, goal statement erventions/approaches, responsible for each lan review and discontinuation				
	director of nursing (develop policies an plan development a policy changes. The care plans to ensur diagnoses are address.	THOD OF CORRECTION: The (DON) or designee could d procedures related to care and educate staff related to the de DON could audit resident re all pertinent nursing ressed, and report results to ce committee for follow up.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/8/16

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0359

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

800 MEDICAL CENTER DRIVE, PO BOX 800

MAYO CI	INIC HEALTH SYSTEM - FAIRMONT	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1	
(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 5 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		
	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:		Corrected.	
	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			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	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.					
	was observed to wh	on 11/8/16, at 12:31 p.m. R28 neel himself to and from the offered to assist him with				
		on 11/8/16, at 12:34 p.m. no structions or sheets were room.				
	director of nursing of is a deficiency of out attempting to work DON stated there is resident's room to define the control of	11/8/16, at 3:30 p.m. the (DON) stated that "ambulation urs," and the facility was on improving this task. The hould be a form inside of the document exercise activity. at walking to and from meals				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00359	B. WING		11/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO CLINIC HEALTH SYSTEM - FAIRMONT			CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 7	2 565			
		time of day, and consequently day may work better.				
	p.m. the DON confi	erview on 11/8/16, at 4:02 rmed there was not a walking sheet located in R28's room at				
		of the breakfast meal on n. R28 was observed to wheel g room.				
	11/7/16, at approxir	of the breakfast meal on mately 8:30 a.m. R6 was not oulated to the morning meal.				
	at 1:04 p.m. R6 wa	of the noon meal on 11/7/16, s wheeled back to the room by t offered by staff to ambulate.				
	dated 11/8/16, iden	n artificial right shoulder, as				
	R6 was to be walke meals and activities assist of one to two	updated 10/31/16, indicated ed- starting 10/31/16 to/from s with a wheeled walker and staff. Resident may not tance, do what she can.				
	period 10/31/16-11/ two of the seven da	acking sheets for the time /6/16, included only an "X" on ays (11/5 and 11/6/16), with no The "X" indicated that R6 had				
	had a BIMS score of	dated 8/3/16, indicated R6 of 13 (cognitively intact) and assistance of one staff for				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY
		00359	B. WING		11/0	09/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYST	FM - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 8	2 565			
	locomotion.					
	2/29/16, indicated I to weakness, interr	ties of daily living ehabilitation potential dated R6 was at risk for decline due mittent pain and history of falls; an to improve abilities related				
	assistant (NA)-A st program and show including the ambu 10/31/16 -11/6/16 v walked to and from also present and in difficult time getting	ated R6 had an exercise ed survey staff a binder lation tracking sheets for which indicated R6 had been meals on 11/6/16. NA-F was dicated she sometimes had a R6 to ambulate to the meals; ind a reason" not to walk.				
	walk today and did	n 11/8/16, R6 stated she did not not walk all day on 11/7/16. she had refused ambulation.				
		sing progress notes for the 1/16-11/9/16 did not reveal she ation.				
	R15 required super transfers, and amb only once or twice of set-up or physical h	PS, dated 9/21/16 identified rvision and assist of one for ulated in room and corridor during look back period with no nelp from staff. The MDS core of 15 (cognitively intact).				
	4/12/16, identified the assistance with his during transitions. In 10/4/16, indicated I	vities of daily living (ADL) dated riggers due to needing cares, and balance issues R15's care plan revised R15 ambulated independently sion of one with a walker and				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 11/0	0,1010
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	used a wheelchair for longer distances independently.					
	walking list instructor to/from meals follow hallway. R15's daily	he daily walking list. The daily ed caregivers to ambulate R15 wing with wheelchair or in walking list, from the previous ot include any documented				
	stated he transfers	on 11/7/16, at 12:42 p.m. R15 self from his recliner chair to further indicated he uses his motion.				
		8 a.m. R15 was observed hallway in his wheelchair to ch.				
		11/9/16, at 11:43 a.m. NA-G tes with a walker and one ng shift.				
	stated R15's family when they visit. RN walker and was foll	11/9/16, at 12:22 p.m. RN-B walks with him almost daily -B indicated R15 used a owed by wheelchair with er stated R15 was not on a program.				
	dated 11/9/16, iden ankylosing spondyli inflammation of the	ated in the medical record tified current diagnoses of itis of the spine (arthritic joints of the spine which can ility) and osteoarthrosis.				
	identified R8 require staff person for tran	quarterly MDS dated 8/11/16, ed limited assistance of one nsfers and walking in the also identified a BIMS score				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
	of 13 (cognitively in	tact).				
	R8 triggered due to activities of daily livi issues during transi for decline in ADL's with arm weakness wheelchair for locor to avoid complication					
	R8 had limited phys	revised on 10/08/16 indicted sical mobility related to s to walk around the square 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.					
		on 11/8/16, at 1:03 p.m. R8 ed in his wheelchair, playing				
	3:49 p.m. until 5:56 lobby playing dice g	s observation on 11/8/16, from p.m., R8 was seated in the games with other residents. ed to be approached about				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00359	B. WING		11/0	9/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT 800 MEDI		STATE, ZIP CODE R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	During interview on indicated R8 should day. NA-A stated the charted on a sheet which was blank for time (4:50 p.m.). During interview on and NA-B indicated times per day, which walking list and trans RN-B at some point. During interview on stated he had not with the book of the	11/8/16, at 4:47 p.m. NA-A d walk three to four times per ne information should be kept at the nursing station, in the current date as of this 11/8/16, at 4:59 p.m. NA-C I R8 should walk three to four the was documented on a disferred into the computer by the during the month. 11/8/16, at 5:04 p.m. R8 walked all day today. 11/9/16, at 7:45 a.m. NA-D IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	2 565			

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PRINTED: 12/09/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00359 11/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 **MAYO CLINIC HEALTH SYSTEM - FAIRMONT** FAIRMONT, MN 56031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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.

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incontinence.

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

registered nurse (RN)-A indicated R8 had a Stage II PU on his right buttock that had been present

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

During interview on 11/6/16, at 2:02 p.m.

since 3/10/16, and was recurrent.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00359	B. WING		11/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	·M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 13	2 565			
	once or twice a day	ed the staff repositioned him , and he could transfer himself neelchair to go to the				
	During observation on 11/8/16, at 1:03 p.m. R8 was seated in his wheelchair, playing cards in the lobby.					
	3:49 to 5:56 p.m., F his wheelchair and significant changes	observations on 11/8/16, from R8 was noted to be seated in was not observed to make in his position independently. Eved to remind R8 to shift his				
	stated he stood up times daily when he	11/8/16, at 5:56 p.m., R8 on his own about three or four took himself to the bathroom se receive repositioning or is weight from staff.				
	assistant (NA)-A inc four times during th	11/8/16, at 4:47 p.m. nursing dicated R8 walked three or e day and was independent room. R8 did not receive g from staff.				
	and NA-C indicated skin concerns for R	f during the day, was not				
	and NA-D stated R	11/09/16, at 7:45 a.m. NA-A 8 did not have any specific am while in the wheelchair.				
		on 11/9/16, at 12:25 p.m. R8's bserved with RN-A, who				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	observed total area with an open slit in shiny red tissue to 10.8 cm by 1 cm. During interview on DON indicated she himself around enowere not encouragi. The facility policy, eskin Integrity, dated be assessed for risalteration. Nursing interdisciplinary plaaltered skin integrit. SUGGESTED MET director of nursing develop policies an ensuring the care peducate staff related DON could audit reaccordance with the to the quality assurate.	was a Stage II PU, with an of 4 cm by 5 cm of redness the center which was noted the wound base, measuring 11/9/16, at 11:17 a.m. the thought R8 usually moved ugh in his chair and that staff ng him to reposition. Intitled Integumentary System: d 11/9/16 indicated patients will k of developing a skin will develop an individualized, n of care for prevention of y on hospitalized patients. THOD OF CORRECTION: The (DON) or designee could d procedures related to blan is implemented and d to the policy changes. The sident cares for completing in e care plan, and report results ance committee for follow up.	2 565			
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			12/8/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	written order from t	possible unless there is a he attending physician that the in bed or the resident bed.				
	by: Based on observatireview the facility fabruising/bleeding for	ent is not met as evidenced on, interview and document alled to monitor or 1 of 3 residents (R15) ressure related skin conditions.		Corrected.		
	Findings include:					
	diagnosis of thromb platelets in the bloo	agnosis report included pocytopenia (deficiency of d that causes bleeding into g, and slow blood clotting after				
	have two dime size lighter purple bruisi approximately 3 ce During interview wit stated he obtained through door ways,	p.m. R15 was observed to d dark purple bruises with ng around the area ntimeters (cm) in diameter. th resident at this time, he the bruises when going reaching and bumping right at 11:38 a.m. R15 stated, "I				
	included an order for used to suppress the effect of increased milligrams (mg) by platelets (compone	ysician orders dated 9/27/16 or prednisone (a medication ne immune system with a side bruising tendency) 10 mouth in the morning for low nt of the blood that help the order on 10/17/16 to decrease				

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NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - FAIRMONT B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031	STATEMENT OF DEFICI AND PLAN OF CORREC
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800	
MAYO CLINIC HEALTH SYSTEM - FAIRMONT	NAME OF PROVIDER OF
	MAYO CLINIC HEAD
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)	PREFIX (EACH
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/o) 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 (MAR1) 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 efeated to R15's risk	Review of 10/31/16 drawn. Fig. 22,000-3: reference L. The plaborator platelet of Review of identified with risk for ulcers, distribution in the plate of the plat

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	for bleeding/bruisin in there".	g, stating "that should've been				
	of nursing (DON) in problems were to be documentation she location, measurem checking a box for The DON stated he completed by licens would be document DON further stated care plan developed disorder so that stated plan.	11/9/16, at 12:50 p.m. director idicated all non-pressure skin be documented on a wound et which includes wound type, nent, drainage, odor, and updating care plan as needed. For expectation was for it to be sed staff and that bruises ted weekly until resolved. The the expectation was to have a d related to the clotting ff could follow the identified				
	11/16 medication a and treatment adm Review of the docu monitoring of the ric review of R15's wo	ility provided copies of the dministration record (MAR) inistration record (TAR). ments lacked any mention nor ght hand bruise. In addition, and documentation dated is, lacked any monitoring sing.				
	for Skin Alterations Surgical, Vascular, Rashes) instructs to document the follow alteration, measure TAR for weekly me	velop, review and update care as are				
	The director of nurs	THOD OF CORRECTION: sing (DON) or designee could ies related to monitoring of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00359	B. WING		11/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTI	-M - FAIRMONI	T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 18	2 830			
	changes. The DON conditions for proper monitoring and repressurance committee.	l educate staff related to the N or designee could audit skin er documentation and ort results to the quality ee for further follow-up.				
2 900	. , .	5 Subp. 3 Rehab - Pressure	2 900			12/8/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores by treatment and services to be revent infection, and prevent by eloping.				
	by: Based on observat review the facility fa promote healing of 1 resident (R8) revi recurrent stage II p partial-thickness los	ent is not met as evidenced ion, interview and document ailed to provide services to a pressure ulcer (PU) for 1 of lewed who experienced a ressure ulcer (defined as a ss of skin with exposed and bed that is viable, pink or		Corrected.		

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00359	B. WING		11/0	09/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT 800 MEDI		STATE, ZIP CODE R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	red, moist, and may ruptured serum-fille Findings include: R8's most current of (MDS) assessment had two stage II presidentified a Brief Int (BIMS) score of 13 R8's care area assoulcers dated 3/8/16 for pressure ulcers cushion to reduce of immobile and inconstate, and had a his plan to avoid composite and inconstate, and had a his plan to avoid composite assistant urinary incontinence daily living and weat identified R8 had a buttocks. Intervent monitoring and meat treatments as order load [reduce pressure ulcate field when possion awake for pressure wheelchair cushion R8's face sheet, day diagnoses of ankylo (arthritic inflammatic which can affect gain incontinence.	y also present as an intact or ed blister). quarterly Minimum Data Set edated 8/11/16, identified R8 essure ulcers. The MDS also erview for Mental Status (cognitively intact). essment (CAA) for pressure identified R8 had risk factors and required a special seat or relieve pressure, was attinent, had altered mental story of PU; proceed to care lications. d 11/7/16, indicated R8 was at cers related to needing the with bed mobility, frequent expressure ulcer on the right ions included: assessing, asurement of the wounds, asurement of the wounds, ared and encouraging R8 to off ure] every 15-20 minutes to the ible throughout the day while reduction and use of	2 900			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00359	B. WING		11/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	·M - FAIRMONI	ICAL CENTE NT, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	development of preindicated a total scoof points should have was indicated as a points) which indicated pressure ulcer development of 3/10/R8 initially started work the period of 3/10/R8 initially started work the most recer on 10/23/16, indicated 60% eschar (brown 20% granulation (not a darker red color a wound bed during tissue (light pink conduring the wound homeasured 1.2 centing the wound homeasured 1.2 centing the day, as wound be day, as wound be day, as wound be day, as wound be day, as wound the day, as wound the day, as wound be day, as wound be day, as wound be day, as wound the day, as wound be day,	ssure ulcers) dated 10/28/16, pring of 24 (maximum number we be 23, friction risk score 4 out of a possible of only 3 ated R8 was not at risk for elopment. entation flow sheets for the 16 through 11/6/16, indicated with a 2 centimeter (cm) by 2.6 area on the right buttocks healed over and re-opened at measurements documented ted a wound bed which was or black, non-viable tissue), ew connective tissue, usually are that forms on the surface of 3 healing) and 20% epithelial lored tissue which forms ealing process), which was meters (cm) in size by 1.0 cm. PT) progress note, dated 8 had a small, superficial the tupper buttock and would shting this area intermittently well as to keep the area clean PT progress note did not ment of the wheelchair				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT 800 MEDI		STATE, ZIP CODE R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	vinyl style seat cush experience some d wound area while ly R8 indicated he did located on his butto wheelchair. During observation at 1:02 p.m. license observed R8's PU. bathroom, was able grab bar next to the for his wound care. removed a foam drocleansed R8's butto patted dry. LPN-A rher hands and indic pressure ulcer local LPN-A reported it darea was observed a very small slit in tiflaking skin. LPN-A redness as 4 cm x wound, LPN-A appl the ulcer. LPN-A in wheelchair cushion unsure whether a daried/reassessed sii. During observation was seated in his wolbby. R8 demonst signs of discomfort. During continuous of 3:49 to 5:56 p.m., Fhis wheelchair and significant changes	s seated on a blue colored, nion. R8 stated he did iscomfort on his buttock to the ring in bed at night. However, not have pain in the wound ock while seated in the with the surveyor on 11/7/16, and practical nurse (LPN)-A R8 wheeled himself into his a to stand up, hold onto the attoilet and to remain standing LPN-A donned gloves and essing from R8's buttocks, ocks with normal saline and emoved her gloves, cleansed atted and the right buttock, id not contain eschar. The to be primarily reddened with the center with non-adherent, measured the entire area with 5 cm. After measuring the ited a clean foam dressing to dicated R8 had the current for quite awhile and was ifferent cushion had been note development of the PU. on 11/8/16, at 1:03 p.m. R8 wheelchair, playing cards in the trated no verbal/non-verbal	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE IT, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 22	2 900			
	weight during the ol	bserved timeframe.				
	stated he stood up times daily when he and did not otherwis reminders from state seated. R8 indicate never been evaluat development of the "they sure could!" During interview on assistant (NA)-A incomposition of the four times during the	11/8/16, at 5:56 p.m., R8 on his own about three or four took himself to the bathroom se receive repositioning nor ff to shift his weight while d his wheelchair cushion had ed and/or changed after buttock PU; however, stated 11/8/16, at 4:47 p.m. nursing dicated R8 walked three or the day and was independent froom. R8 did not receive g from staff.				
	and NA-C indicated skin concerns for R repositioned himsel	If during the day, was not ion himself and that staff were				
	indicated R8 should and was aware R8 bottom. NA-D was	11/09/16, at 7:45 a.m. NA-A d walk several times per day did have a wound on his present also at this time and ave any specific repositioning e wheelchair.				
	(MDS Coordinator) several times per d provided with a new concern he was call bumping them into she was unaware o	on 11/9/16, at 8:35 a.m. RN-B indicated R8 was to walk ay. RN-B stated R8 had been wheelchair due to the using trauma to his ankles, the wheels. RN-B confirmed of any seat cushion changes lent of R8's buttock ulcer.				

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

NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
MAYO C	LINIC HEALTH SYSTEM - FAIRMONT		CAL CENTE T, MN 5603 [.]	R DRIVE, PO BOX 800 1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	:S 'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 23		2 900		
	During observation on 11/9/16, at 12:25 buttock ulcer was observed with RN-A, confirmed: the area was a stage II PU, area of 4 cm x 5 cm of redness had an in the center with shiny red tissue exter the wound base, which measured 0.8 ccm.	who the total open slit iding to			
	When interviewed on 11/9/16, at 11:17 director of nursing (DON) indicated she R8 usually moved himself around enoughair and so staff were not encouraging reposition. The DON indicated they have reassessed R8's ability to reposition himadequately in the wheelchair since the developed. The DON thought the area a location [on the buttock] R8 sat on, wheelchair and was unaware of any rechanges in his wheelchair cushions.	thought gh in his I him to d not nself PU was not in hile in the			
	The facility policy, entitled Pressure Ulc Management, dated 11/9/16 indicated pulcers were assessed on admission, at of treatment, with each dressing change intervention, upon transfer, and prior to discharge.	ressure initiation			
	The facility policy, entitled Integumental Skin Integrity, dated 11/9/16 indicated pbe assessed for risk of developing a sk alteration. Nursing will develop an indivinterdisciplinary plan of care for prevent altered skin integrity on hospitalized parpolicy did not address other preventive for pressure ulcers beyond skin assess weekly wound documentation.	atients will in dualized, ion of ients. The measures			
	SUGGESTED METHOD OF CORRECT The director of nursing (DON) or design				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	PLETED
		00359	B. WING		11/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTE	·M - FAIRMONI	ICAL CENTE IT, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	revise policies and pressure ulcer devereassessment of ris with changes in skill designee could educhanges and audit ongoing compliance could report finding committee for follow	procedures related to elopment related to elopment related to eks and repositioning ability in integrity. The DON or locate staff related to the resident care to ensure e. The DON or designee is to the quality assurance	2 900			
2 915	Subp. 6. Activities comprehensive reshome must ensure A. a resident is treatments and senabilities in activities deterioration is a not the resident's condipart, activities of daresident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this ily living includes the as, and groom; d ambulate;	2 915			12/8/16
	by:	ent is not met as evidenced on, interview and document		Corrected.		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00359	B. WING		11/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 25	2 915			
	necessary to mainta	ailed to provide services ain ambulation ability for 4 of 4 R15, R28) reviewed for ing (ADL).				
	Findings include:					
	assessment dated a extensive assistance of the corridor. The M non-Alzheimer's de	imum Data Set (MDS) 8/3/16, identified R28 required se of two for transfers and of two people for ambulation in IDS identified a diagnosis of mentia. The MDS identified a Mental Status score of 13				
	ADL's dated 5/25/10 needing assistance	ssessment (CAA) related to 6, identified triggers due to with cares, cognitive ance issues; proceed to care o assist with ADL's.				
	R28 required assist and locomotion, usi	t revised 10/4/16, indicated cance of one staff with walkinging a walker and wheelchair. Duraged to walk to and from s.				
		lists, from the previous 30-day de any documented				
		apy (PT) discharge 3/7/16, indicated R28 was to m the dining room with staff				
	During observation wheeled himself fro	on 11/7/16, at 12:52 p.m. R28 m the dining room; R28 was				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	1 11/0	0,2010
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 26	2 915			
	not observed to be staff assistance.	ambulated from the meal with				
	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."					
	wheeled himself to the noon meal and	on 11/7/16, at 1:55 p.m. R28 and from the dining room for was not walked in accordance dation from the PT discharge				
	was observed to wh	on 11/8/16, at 12:31 p.m. R28 neel himself to and from the offered to assist him with				
		on 11/8/16, at 12:34 p.m. no structions or sheets were 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.					
	p.m. the DON confi	erview on 11/8/16, at 4:02 rmed there was not a walking sheet located in R28's room at				
		of the breakfast meal on n. R28 was observed to wheel				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00359	B. WING		11/0	9/2016
	PROVIDER OR SUPPLIER	EM - FAIRMONT 800 MEDI		STATE, ZIP CODE R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 915	himself to the dining R6 During observation 11/7/16, at approxir observed to be amb During observation at 1:04 p.m. R6 was visitors and was no R6's face sheet loc dated 11/8/16, iden osteoarthritis and a well as history of fa R6's care plan last R6 was to be walke meals and activities assist of one to two always walk full dist R6's ambulation tra period 10/31/16-11/ two of the seven da distance recorded. walked. R6's quarterly MDS had a BIMS score of required extensive slocomotion. R6's CAA for activit (ADLs)/functional re 2/29/16, indicated F to weakness, intern	of the breakfast meal on mately 8:30 a.m. R6 was not bulated to the morning meal. of the noon meal on 11/7/16, is wheeled back to the room by the offered by staff to ambulate. ated in the medical record tified diagnoses of an artificial right shoulder, as lls. updated 10/31/16, indicated and staff. Resident may not tance, do what she can. cking sheets for the time (6/16, included only an "X" on any (11/5 and 11/6/16), with no The "X" indicated that R6 had assistance of one staff for	2 915			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MAYO C	LINIC HEALTH SYSTI	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 915	During interview on stated R6 had an e survey staff a binde tracking sheets for indicated R6 had be on 11/6/16. NA-F with she sometimes had ambulate to the me reason" not to walk During interview on walk today and did R6 did not indicate. Review of R6's nurritime period of 10/3 had refused ambulated ambulated ambulated required supertransfers, and ambonly once or twice of set-up or physical hidentified a BIMS set. R15's CAA for active 4/12/16, identified to assistance with his during transitions, included medication.	11/7/16, at 2:00 p.m. NA-A xercise program and showed or including the ambulation 10/31/16 -11/6/16 which een walked to and from meals was also present and indicated d a difficult time getting R6 to eals; stating R6 would "find a 11/8/16, R6 stated she did not not walk all day on 11/7/16. she had refused ambulation. sing progress notes for the 1/16-11/9/16 did not reveal she	2 915			
	hearing; Proceed to level of functioning. R15's care plan reviambulated independent	rised 10/4/16, indicated R15 dently to needing supervision r and used a wheelchair for				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ige 29	2 915			
	walking list instruct to/from meals follow hallway. R15's daily 30-day period did n walks.	he daily walking list. The daily ed caregivers to ambulate R15 wing with wheelchair or in walking list, from the previous of include any documented				
	stated he transfers self from his recliner chair to his wheelchair but further indicated he uses his wheelchair for locomotion.					
		8 a.m. R15 was observed n hallway in his wheelchair to ch.				
		11/9/16, at 11:43 a.m. NA-G tes with a walker and one ng 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.					
	identified R8 require staff person for tran	quarterly MDS dated 8/11/16, ed limited assistance of one nsfers and walking in the also identified a BIMS score tact).				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

A. BUILDING:

(X3) DATE SURVEY COMPLETED

00359

11/09/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING ___

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	T, MN 56031	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
2 915	Continued From page 30	2 915		
	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.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00359		B. WING		11/(09/2016
NAME OF PROVIDER C	R SUPPLIER				STATE, ZIP CODE		
MAYO CLINIC HEA	LTH SYSTI	EM - FAIRMONT		CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
PREFIX (EACI	H DEFICIENC	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
indicated day. NA charted of which was time (4:5). During ir and NA-times per walking I RN-B at the During ir stated her buring ir confirmed buring ir indicated day, and walking is month's However which has walking is opportuning for the DON computed be documentating the political confirmed by the DON computed by the DON com	-A stated to na sheet as blank for 50 p.m.). Interview on B indicated r day, which ist and trainsome point atterview on the had not what the results sheets. Rise ambulation r, it only income with assist and trains are walking a four time with assist urther interlaindicated are system, a mented in the recurrence ting arm N confirme	d walk three to four he information sho kept at the nursing refered the current date at 11/8/16, at 4:59 pt R8 should walk the was documented before into the cost during the month of 11/8/16, at 5:04 pt walked all day toda at 11/9/16, at 7:45 at ld walk several time of the walking several should be recorded by the provided the provided the provided the provided the provided the provided the provided, R8 only walk average of once of sheets indicated F8 daily with a wheet ance of one staff. Wiew on 11/9/16, at the walks were not although sometimes the nursing progress the provided in accordance with a coordance with a was expected sin accordance with the four sheets in accordance with the walks were not although sometimes the nursing progress at the coordance with a coordance with accordance with the walks were not although sometimes the nursing progress at the coordance with	uld be g station, as of this	2 915			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00359	B. WING		11/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 32	2 915			
	Restorative Program nursing care is directly abilities of residents of function and indectly altered life style, and and complications of	•				
	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 (21) days.	R CORRECTION: Twenty-one				
21025	MN Rule 4658.0615	5 Food Temperatures	21025			12/8/16
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co	us food must be maintained at heit (four degrees centigrade) grees Fahrenheit (66 degrees re. "Potentially hazardous and subject to continuous time ontrols in order to prevent the five growth of infectious or anisms.				
	by: Based on observati review the facility fa were held or served prevent foodborne i	ent is not met as evidenced ion, interview and document ailed to ensure pureed foods d at the proper temperature to illness for 4 of 4 residents 33) who had mechanically		Corrected.		

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Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AT	DRESS CITY	STATE, ZIP CODE		
NAME OF	TIOVIDEIT OIT SOLT EIEIT			R DRIVE, PO BOX 800		
MAYO CLINIC HEALTH SYSTEM - FAIRMONT		NT, MN 5603				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
				DEFICIENCY)		
21025	Continued From pa	nge 33	21025			
		.go	2.020			
	altered diets.					
	Findings include:				ļ	
	During observation	of lunch meal on 11/8/16, at				
		aide (DA)-A used a food				
		eck the temperatures of the				
		able she was preparing to				
		room. Food temperatures				
		he Daily Service log and DA-A				
		onto trays. To the left side of ea was a tray with four covered				
		icken and biscuits. DA-A				
		od temperatures are not taken				
		ause it is checked in the				
		eed meals are kept in covered				
		ated to side of steam table unti				
		er stated pureed meals are				
		d during dish up. At 12:08 dy to serve the bowls of				
		the surveyor requested a				
		of the pureed chicken and				
		letion, DA-A revealed a				
		e of 110 and 111 degrees				
		in the four bowls. DA-A				
		rving temperature of 140				
		ired, but since it was cooked				
	,	n enough to serve, and the meals delivered.				
	proceeded to have	the meals delivered.				
	During interview on	11/8/16, at 3:23 p.m. the				
		M) stated after food is cooked				
		of 165 degrees F it is pureed,				
		and delivered on a tray with				
		ood items. No holding nor				
		e checks are routinely				
		has been pureed. At 4:01				
		a safe serving temperature is d confirmed that serving				
		reed food at lunch today			ļ	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00359	B. WING		11/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	CAL CENTE T, MN 5603 ⁻	R DRIVE, PO BOX 800 I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21025	Continued From pa	ge 34	21025			
	(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.					
21390	390 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING: COMPLETED

00359 B. WING ______ 11/09/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, S	STATE, ZIP CODE	
MAYO C	I INIC: HEALTH SYSTEM - FAIRMONT			R DRIVE, PO BOX 800	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUR REGULATORY OR LSC IDENTIFYING INFORMATION	JLL	, MN 5603 ⁻ ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	reduce risk of transmission of infectious as D. in-service education in infection prevention and control; E. a resident health program including immunization program, a tuberculosis programined in part 4658.0810, and policies ar procedures of resident care practices to as the prevention and treatment of infections. F. the development and implementation employee health policies and infection corpractices, including a tuberculosis program defined in part 4658.0815; G. a system for reviewing antibiotic used. H. a system for review and evaluation products which affect infection control, such disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness current standards of practice in infection of	gents; g an gram as nd ssist in ; on of ntrol n as se; of ch as	21390		
	This MN Requirement is not met as evide by: Based on observation, interview and docu review, the facility failed to ensure proper I hygiene during personal cares for 1 of 1 re (R28) observed during morning cares. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 8/3/16, indicated requirextensive assistance for dressing and toile and limited assistance with personal hygie one staff member. The MDS also identified was frequently incontinent of urine. During observation on 11/09/16, at 7:05 a. nursing assistant (NA)-E was observed completing morning cares for R28. NA-E observed to don gloves, walk R28 to the	ment hand esident red eting ene of ed R28 m.		Corrected.	

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PRINTED: 12/09/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00359 11/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 **MAYO CLINIC HEALTH SYSTEM - FAIRMONT** FAIRMONT, MN 56031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21390 Continued From page 36 21390 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

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(21) days.

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

TIME PERIOD FOR CORRECTION: Twenty-one

ensure ongoing compliance.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00359	B. WING		11/09/2016		
NAME OF PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE			
MAYO CLINIC HEALTH SYSTE	M - FAIRMONI	CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21535 Continued From pag	ge 37	21535				
21535 MN Rule4658.1315 Drug Usage; Genera	Subp.1 ABCD Unnecessary al	21535			12/8/16	
must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adeq D. in the presen which indicate the discontinued. In addition to the dr part 4658.1310, the with provisions in the Code of Federal Reg 483.25 (1) found in A Operations Manual, Long-Term Care Fac Department of Health Care Financi This standard is inconvailable through the system and the Stat subject to frequent of the subject to frequent of the converse of the conv	uate indications for its use; or ice of adverse consequences ose should be reduced or ug regimen review required in a nursing home must comply e Interpretive Guidelines for gulations, title 42, section Appendix P of the State Guidance to Surveyors for cilities, published by the th and Human Services, ng Administration, April 1992. Orporated by reference. It is e Minitex interlibrary loan e Law Library. It is not		Corrected.			

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N			E CONSTRUCTION		SURVEY PLETED
				7.1. 20.22.1.0.1			
		00359		B. WING		11/0	09/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT		T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 38		21535			
	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.						
	included orders for milligrams (mg) 2 to	cian orders dated 9/ acetaminophen tab ablets by mouth eve and Tramadol 50 mo N pain control.	let 500 ry 6 hours				
	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.						
	a goal indicating R2 relief of pain and in unlicensed nursing side effects of pain pain characteristics		idequate and ument for r /record rd/report to erbal pain,				
		edication administra and November 2010					
	- R23's MAR dated received 9 doses of doses of PRN Tram		en and 14				

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-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		00359	B. WING	11/09/2016	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
MAYO CLINIC HEALTH SYSTEM FAIRMONT 800 MEDIC		EM FAIRMONT 800 MED	ICAL CENTER DRIVE, PO BOX 800		

MAYO CLINIC HEALTH SYSTEM - FAIRMONT 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE
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 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 "1s 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

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PRINTED: 12/09/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00359 11/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 **MAYO CLINIC HEALTH SYSTEM - FAIRMONT** FAIRMONT, MN 56031 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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.

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date of 10/31/16.

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

R53's Minimum Data Set (MDS) assessment and Care Area Assessments (CAA) were in progress

and not fully completed for for review.

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		11/0	09/2016
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTE	EM - FAIRMONT 800 MEDIC		RTATE, ZIP CODE R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21535	R53's pain assessmindicated R53 had I which was sharp in oxycodone were list the most effective lithe most effecti	ge 41 nent, undated and unsigned, eft hip surgical incision pain intensity. Tylenol, Vicodin and ted as medications used, with sted as oxycodone. form dated 11/3/16, indicated ril for muscle spasm and th physical therapy (PT). rders dated 11/1/16, indicated ne (a short acting narcotic pain rams (mg) every four hours as rders dated 11/3/16, indicated a muscle relaxant) 5 mg three n days PRN for muscle dated 11/3/16 - Flexeril for ntinue to work with PT, p and walk often. Order for 7 days PRN for muscle heets dated 11/16, indicated Flexeril a total of ten times d on 11/3/16, and had been done 5 mg on 28 occasions, es/day since the order was n Progress notes, dated 11/16 umentation for pain levels with N) pain medications only ation of the reason for the pain a pain rating recorded on 12 yels were listed ranging from a pain rating recorded on 12 yels were listed ranging from a scale). No follow up response	21535			

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PRINTED: 12/09/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ___ 00359 11/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 MAYO CLINIC HEALTH SYSTEM - FAIRMONT

MAYO C	INIC HEALTH SYSTEM . FAIRMONT	IT, MN 5603	1	
(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
		1AG 21535	CROSS-REFERENCED TO THE APPROPRIATE	
	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			

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PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MAYO CLINIC HEALTH SYSTEM - FAIRMONT (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (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			00359	B. WING		11/0	9/2016		
Calculation Calculation	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	MAYO C	MAYO CHNIC HEALH SYSTEM - FAIRMONT							
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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	21535	significant degree of treatments, stating comfortable." RN-E due to his recent or During interview on practical nurse (LPI R53's pain level wit R53 had tried hot a hip. LPN-B indicate offer R53 the Flexe scheduled basis to pain, which had inc During interview on it was verified that scharting pain levels medication, but also pain medications or sheets so that staff effectiveness. During interview on consultant pharmache evaluating effect an hour or so after effectiveness and the The facility policy, edated 7/2/14 indicate accepted as the mocurrent level of pain intensity scale was For long term care are reassessment should interventions, with a report of pain, exact discharge or transfer	of pain during his dialysis R53 appeared "fairly E felt most of R53's pain was thopedic surgery. 11/8/16, at 1:09 p.m. licensed N)-B stated she monitored h medication passes and that nd cold packs today for the left ed nursing staff were trying to ril 3 times/day on a more see whether this helped his reased the last couple of days. 11/8/16, at 3:25 p.m. the DON staff should not only be when they give the pain to the follow up response to the nother the PRN medication flow could evaluate the 11/9/16, at 1:22 p.m. the coist (CP) indicated staff should tiveness of pain medications giving them, to monitor for his should be documented. entitled Pain Management, the patient's self-report is lost accurate measure of the nother than a caceptable tool. Settings, the policy indicated all document of pain and at ear to another level of care.						

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
_		00359			11/0	9/2016
800 MEDIC				STATE, ZIP CODE R DRIVE, PO BOX 800		
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	T, MN 5603			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 44	21535			
	outcomes for the in opioid).	tervention (e.g. efficacy of an				
	SUGGESTED MET director of nursing of conjunction with the develop policies an monitoring of pro reparameters, and m DON could educate changes in policy a resident records to implemented. Resto the quality assurarecommendations to	THOD OF CORRECTION: The (DON) could work in e consultant pharmacist to d procedures related to e nata (PRN) medication use, onitoring of effectiveness. The e staff related to these and procedure, and audit ensure process changes are ults of audits could be reported ance committee for further to ensure ongoing compliance. R CORRECTION: Twenty-one				

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