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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NZLC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00359

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245274**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/31/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
On 12/31/2013, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 11/1/13 standard survey, Effective 12/11/2013. Refer to the CMS 2567b for health PCR.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 01/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/10/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/28/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245274

March 20, 2014

Ms. Dawn Campbell, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive, PO Box 800
Fairmont, Minnesota 56031

Dear Ms. Campbell:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective December 11, 2013 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 located in rooms .

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 22, 2014

Ms. Dawn Campbell, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive, Po Box 800
Fairmont, MN 56031

RE: Project Number S5274023

Dear Ms. Campbell:

On December 13, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 1, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 31, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 1, 2013, effective December 11, 2013 and therefore remedies outlined in our letter to you dated December 13, 2013, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Kathryn Serie

Kathy Serie, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 507-537-7158 Fax: 507-344-2723

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245274	A. Building B. Wing	12/31/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0161 Reg. # 483.10(c)(7) LSC	Correction Completed 11/01/2013	ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 12/11/2013	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 12/11/2013
ID Prefix F0278 Reg. # 483.20(g) - (i) LSC	Correction Completed 12/11/2013	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 12/11/2013	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/11/2013
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 12/11/2013	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 12/11/2013	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 12/11/2013
ID Prefix F0322 Reg. # 483.25(g)(2) LSC	Correction Completed 11/25/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/11/2013	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/11/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	16022	1-22-14	03048	12/31/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
11/1/2013	YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NZLC

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

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(L1) **245274**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 12/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 01/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-245274

At the time of the standard survey completed November 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7024

December 13, 2013

Ms. Dawn Campbell, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive
PO Box 800
Fairmont, Minnesota 56031

RE: Project Number S5274023

Dear Ms. Campbell:

On November 1, 2013, the Minnesota Department of Health completed a standard survey at your facility, and on December 11, 2013, the Minnesota Department of Public Safety conducted a survey to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>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;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, MN 56258-2529

Office: (507) 537-7158
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 11, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 1, 2014 (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 1, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697
Enclosure

cc: Licensing and Certification File

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING _____ B. WING _____	11/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Kmf approved 12/30/13	
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that resident fund accounts were insured with a surety bond. This had the potential to affect 33 of the 34 current residents who had a fund account managed by the facility. Findings include: During interview on 10/31/13, at 1:55 p.m., social worker (SW)-A indicated the total amount currently managed for the 33 residents in the facility totaled $1751.27. SW-A revealed the facility did not have a surety bond and was not sure how it had gotten overlooked. A policy was requested, however SW-A indicated none existed.	F161	A surety bond in the amount of $4,000 was received on 11/1/2013. The Social Services Director and Administrator will work with the Finance Department to ensure that this policy remains in force annually. Correction Date: 11/1/2013 RECEIVED DEC 27 2013 Minnesota Department of Health Marshall	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adam Campbell — TITLE: LNHA — (X6) DATE: 12/27/2013

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.

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

PRINTED: 12/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING _____ B. WING _____	11/01/2013

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

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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct an assessment to determine whether a resident was capable to self-administer medication for 1 of 10 residents (R35) observed during medication administration observation. Findings include: During an observation on 10/31/13 at 8:10 a.m., trained medication aide (TMA)-A was observed to administer a nebulizer treatment to R35. TMA-A placed the prescribed medication into the nebulizer receptacle, attached the receptacle to the face mask, turned on the nebulizer machine and handed the mask to R35. TMA-A stated that R35 preferred to hold the mask to her face during the treatment. TMA-A then advised R35 that she would return in "10 minutes" and exited the room. When asked if R35 had a physician order to self administer the nebulizer treatment, TMA-A stated, "I told her I'd be back in 10 minutes". Twenty minutes later, during an observation on 10/31/13 at 8:40 a.m., TMA-A was observed to re-enter R35's room to administer her second nebulizer treatment. TMA-A was observed to open the nebulizer receptacle (which still had moisture present from the last treatment), open	F176	F176 1) R35 expired on 12/13/13. 2) Currently, there are two residents whose assessments indicate to be appropriate for self-administration of nebulizer treatments. Physician Orders have been obtained and placed on their chart. 3) We will continue to assess residents' abilities for self-administration of medications, following the current policy and procedure. 4) The Director of Nursing or her designee will audit the medication administration process for six months and report results at the Quality Assurance meeting. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited. Proposed Correction Date: ~~1/10/14~~ 12/11/13 admin AC DNS	

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F 176	Continued From page 2	F 176		

the medication ampules and place the medication into the receptacle. TMA-A proceeded to attach the various nebulizer pieces together, hand the nebulizer mask to R35 and turn on the nebulizer machine. As R35 held the mask to her face, TMA-A informed R35 that she would return after the treatment was finished. TMA-A then exited R35's room and continued with medication administration for another resident.

Review of R35's record revealed physician's orders for: albuterol sulfate nebulization solution (2.5 mg/3 ml) 0.083%, 1 vial inhale orally via nebulizer every 6 hours and Pulmicort suspension 0.5 mg/2 ml, 1 vial inhale orally via nebulization two times a day. The record lacked a physician order for R35 to self administer the nebulizer treatments and also lacked an assessment to determine whether the resident was capable of self administration of the nebulizer treatments. The plan of care dated 10/24/13 indicated, "8-6-13 Self Medication: Res (resident) not able to safely self medicate".

When interviewed on 10/31/13 at 11:00 a.m., registered nurse (RN)-A confirmed that R35 did not have a physician order to self administer the nebulizer treatments but thought an assessment to self administer medications had been completed. RN-A was unable to locate any self-administration assessment that determined whether R35 had the ability to safely administer the nebulizer treatments.

A review of the policy/procedure titled, "Self Administration of Drugs" revised 6/08 included the following: "A resident may self-administer drugs if, at the initial care conference, the interdisciplinary team determines that the resident

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F 176	Continued From page 3 is competent to safely and correctly administer their own medications. The decision then needs to be approved by the physician. The nursing staff must obtain a physician's order which includes the medication, dosage, route and any special instructions before the resident will be allowed to administer their own medications."			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide dignified care while staff provided eating assistance for 1 of 1 resident (R10) observed to be totally dependent upon staff for eating and who required individualized positioning to enhance the dining experience. Findings include: R10 was observed during the noon meal on 10/28/13 from 12:21 p.m. until 12:38 p.m.. R10 was observed seated in a geri-chair at a dining room table with nursing assistant (NA)-C assisting R10 during the meal service. R10 was observed to require total assistance with eating and was positioned with her body leaning to the left side of the geri chair on a pillow, head tilted forward, with chin towards the chest, and feet dangling without touching the floor. NA-C was		F241 1) R10 expired on 11/19/13. 2) Residents who use geri-chairs will be provided a dignified dining experience, which includes how they are positioned in their chairs and how assistance is provided with eating. 3) PT/OT assessments will be completed as needed and followed by Nursing staff related to proper positioning in geri-chairs. PT/OT staff will provide re-instruction to Nursing staff if needed. 4) The Director of Nursing or her designee will monitor residents' positioning for comfort and dignity whether in the geri-chair or wheelchair, providing on-the-spot correction of the situation if residents are determined to not be positioned properly. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after	

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F 241	Continued From page 4 observed to place her left hand on R10's forehead, tilt R10's head upward, place food into the resident's mouth, lower R10's head back down and then turn and assist another resident seated at the same table. NA-C was observed to repeat this process until 12:24 p.m. At that time, NA-C left the table and assisted another resident in the dining room. When NA-C returned to assist R10, NA-C was observe to feed R10 using the same process of holding the resident's head up as described previously. At 12:30 p.m., NA-C was noted to converse with registered nurse (RN)-E, who then adjusted R10's geri-chair in a reclined position so R10's feet were elevated and supported by the foot rest. R10 did not lean as far forward in the geri-chair after the chair was re-positioned by RN-E. At that time, NA-C left the area where R10 was seated and RN-E took over assisting R10 with the meal for a short time. During this observation, it was noted that RN-E did not have to tilt R10's head back when food was placed into the mouth. At 12:34 p.m., RN-E left the dining area and NA-D was observed to help R10 with the remainder of the meal. NA-D was observed to re-align R10 by repositioning the pillow on the left side, which was placed between the resident and the armrest on the geri-chair. R10 was positioned in the center of the geri-chair, slightly reclined and head tilted slightly forward. This position improved the resident's ability to eat the food served. R10 was continuously observed in the dining room on 10/30/13 from 6:19 p.m. until 6:42 p.m. during the evening meal. R10 was observed seated in the geri-chair in the upright position. R10's head was leaning toward the left shoulder, with the upper trunk leaning forward in the chair. R10's feet were observed to be dangling without	F 241	the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: ~~1/10/14~~ 12/11/13 approval by DON/admin	

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F 241	Continued From page 5 touching the floor, as the footrest had not been engaged. NA-B was observed to provide assistance with the evening meal by placing the palm of the right hand on R10's forehead, lift the head upward and maintain the head in this position while attempting to place food items into R10's mouth. After the food had been provided, NA-B would lower R10's head, turn away from R10 and assist another resident seated to the left of R10. NA-B was observed to assist R10 in this manner throughout the entire meal. R10 appeared to refuse much of the meal. Although, when offered, R10 did consume some fluids. It was noted that NA-B did not verbally interact with R10 or any of the other three residents seated at this table throughout the entire dining experience. NA-B did not attempt to reposition R10 during this meal observation, except to tilt the head up/down with her hand. R10's record was reviewed and had diagnoses that included: Lewy body dementia and Parkinson's disease. The minimum data set assessment dated 9/11/13, indicated that R10 had functional limitation in range of motion in both the upper and lower extremities on both sides of the body. The undated plan of care indicated R10 required total assistance of 1 with eating. When interviewed on 10/31/13 at 11:10 a.m., RN-A confirmed that R10 had not been positioned properly during both meal observations. She confirmed the poor positioning had not promoted a dignified eating experience for R10. RN-A further confirmed the lack of interaction with R10 during the 10/30/13 supper meal observation was also a dignity concern.	F 241		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 SS=D	Continued From page 6 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R41) reviewed who had a bed rail attached to the bedframe at the time of the MDS assessment.	F	F278 All residents, including R41, will be assessed for side rail use. A new assessment form will be added to the Admission checklist and then assessed, at minimum, quarterly thereafter. R41's side rail assessment has been completed and she will continue to use a 1/2-side rail for bed repositioning. The second rail on the bed will be secured in the down-position. The Director of Nursing will remain responsible for assuring that the use of side rails is accurate from assessment to care plan to placement/removal at the bedside. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited.	

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F 278	Continued From page 7 Findings include: R41's record was reviewed and the quarterly minimum data set (MDS) dated 8/13/13, identified that R41 had severe cognitive impairment and required extensive physical assistance from two staff for transfers and bed mobility. In addition, the MDS indicated that R41 had not used bed rails. During an observation on 10/29/13 at 8:35 a.m., bilateral half side rails attached to the bed frame were observed to be in the up position. The record identified R41's diagnoses as including: stroke with right sided weakness, decreased right shoulder mobility related to a rotator cuff injury, and had a history of falls. The care plan, last updated on 10/24/13, identified that R41 used the two upper half side rails to assist with bed mobility. On 10/29/13, at 4:40 p.m., R41 was observed during the transfer process which required two nursing assistants (NA) and a mechanical lift. Although the side rails were noted to be in the up position on the bed, at no time during the transfer process did R41 attempt to use the side rails on either side of the bed. During interview on 10/30/13, at 2:42 p.m., registered nurse (RN)-A indicated the bed rails had been applied to the bed for a prior resident. RN-A stated when the other resident had been discharged, the rails were not removed prior to R41 getting the bed. RN-A confirmed the facility had not completed any comprehensive assessment related to bed rail use for R41.	F 278	Proposed correction Date: ~~1/10/14~~ 12/11/13 approval phone DON admin	

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care to accurately reflect the passive range of motion (PROM) assistance required for 1 of 3 residents (R10) reviewed who had limitations in range of motion (ROM). Findings include: During observations on 10/28/13 at 12:42 p.m., R13 was observed to have contractures of her upper and lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle). There were no	F 280	F280 R10 expired on 11/19/13. Ten (10) residents are currently receiving range of motion (ROM) services. Their care plans have been reviewed for accuracy. The process for identifying residents with declining ROM will continue and the Director of Nursing or her designee will continue to be responsible for ensuring that exercise programs are followed and written accurately in the care plan. ROM re-training will be added to the orientation checklist for new employees including a return demonstration component. ROM re-training will be addressed at the next NAR meeting. An audit of the system will be completed by the DON and the results reported at the next Quality Assurance meeting. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: ~~1/10/14~~ 12/11/13 approved DN	

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F 280	Continued From page 9 splints observed in place. During interview with registered nurse (RN)-A on 10/28/13 at 10:29 a.m., RN-A verified R10 had upper and lower extremity contractures and stated the resident received staff assistance with ROM exercises routinely. Record review identified R10's diagnoses as: dementia with Lewy bodies, osteoporosis and Parkinson's disease. A quarterly Minimum Data Set (MDS) dated 9/11/13, indicated R10 had severely impaired decision making skills, had functional limitation in ROM of bilateral upper and lower extremities and required total assistance from staff for all activities of daily living (ADL's). During review of the most recent plan of care, revised 9/30/13, it was noted there were inconsistencies regarding interventions for staff direction for completion of range of motion exercises. Under a problem area of Maintenance /Rehab/Restorative, the care plan indicated the resident required staff assistance with "ROM to wrists, fingers and ankles 10 reps (repetitions) 2 times a day." Under a problem area specific to Disease/Diagnosis-Parkinson's disease, the interventions included, "Provide passive ROM to all extremities, 5 repetitions 2 times a day after meals." Under yet another problem area, Focus: Risk-Skin breakdown, the interventions included, "ROM to wrists, fingers, ankles 10 reps each." The care plan had not been revised to include clear direction/intervention for staff to implement regarding the resident's ROM care. Review of the most recent OT assessment dated 7/13/10, a problem list included: bilateral hand and feet contractures, total dependence with ADL's and with transfers. The functional	F 280		

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F 280	Continued From page 10 level/discharge portion of the assessment had documented: "Nursing was instructed to complete PROM to bilateral extremities including wrists, digits & (and) ankles. ROM was instructed to be completed 2 x/day (two times a day) x 10 reps [repetitions] each". No more recent OT assessment was located in the record. During an interview on 11/1/13 at 11:42 a.m., RN-A confirmed the NA's were to perform PROM to all of R10's extremities which would include the wrists, fingers, and ankles. RN-A further confirmed the plan of care was confusing as what intervention, including number/frequency of repetitions, should be implemented related to R10's ROM needs. RN-A stated she would expect staff to perform at least 5 reps BID (twice a day), then added, "Maybe 2-5". However, RN-A confirmed the plan of care had not been revised to accurately reflect the intervention required by staff. The facility's policy, Rehabilitative and Restorative Program, included: "Rehabilitative, restorative, and supportive nursing services include the following:...active and passive range of motion exercises....Residents are assessed and needs addressed in the Plan of Care on admission...Evaluation of care and readjustment of goals occur in a timely manner."	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 11 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide ongoing pain monitoring for 1 of 3 residents (R4) reviewed with pain, failed to provide the proper positioning for 2 of 3 residents (R10 & R41) reviewed who had positioning needs and failed to determine the causal factors related to skin bruising for 1 of 4 residents (R13) reviewed for non-pressure related skin conditions. Findings include: The facility failed to monitor pain for R4 who complained of pain related to a pressure ulcer. During interview with R4 on 10/29/13 at 10:18 a.m. he stated that his right hip hurt. He stated that it was "good and sore, I have a bed sore there and it hurts. They doctor it but it hurts and it keeps me awake at night." During an observation of the affected area at 4:00 p.m. on 10/30/13, following a physician visit at the clinic, registered nurse (RN)-A removed a pink foam dressing from R4's upper right buttock area. When the dressing was removed, a large amount of dark brown drainage was present. The area was approximately the size of a quarter and appeared to be open. A progress note from the physician's visit that day, identified the area as a stage 2 pressure ulcer. When interviewed again on 10/31/13 at 10:00	F 309	F309 R10 expired on 11/19/13. A second request for an OT order to assess the continued use of a geri-chair for R41 is pending. Documentation related to the bruises on R13 has been updated on the Bruise Tracking Sheet. The healing progress will be documented until healed. The Wound Tracking sheet shows the progress of healing for R4's pressure ulcer. The site is smaller as it heals. Also, no reported pain on 12/15 associated with the site. The Director of Nursing and her designee will continue to be responsible for ensuring that documentation accurately reflects the progress of residents' conditions, not limited to the areas of pain control, skin condition, and chair positioning. Through interview and observation, we have determined that the provision of care is performed more accurately than what is reflected in documentation. The Team will work on reducing confusion as to what approaches are current on the care plan. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after	

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	245274	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 12 a.m., R4 continued to complain of hip pain. A significant change Minimum Data Set (MDS) dated 8/28/13, identified that R4 had experienced occasional pain in the last 5 days, that the pain had made it hard to sleep at night, had limited his activity, and that the pain had been rated by R4 at that time as a 3 on a scale of 1-10 (1 the least pain, 10 the worst pain). The corresponding care area assessment (CAA) related to pain, reiterated that the pain made sleep difficult and also limited R4's daily activity. According to the CAA, the plan was to continue with the administration of "as needed" (PRN) pain medication, and notification of the physician if the PRN medication failed to provide adequate control. According to Wound Tracking forms, R4 had complained of pain in the area of his pressure sore. Documentation indicated: (1) on 9/1/13, a stage 1 pressure ulcer had been noted to the upper right buttock, and measured 5 centimeters (cm) by 1 cm, appeared red in color, not open and R4 had identified pain to the area; (2) 9/7/13, stage 1, measured 2 cm x 1 cm, red in color, not open and R4 identified pain to the area; and (3) on 9/15/13, documentation indicated a stage 1 to the right upper buttock which measured 3 cm x 1 cm, red in color, not open and pain had been identified by R4. Review of the record indicated no further assessments related to pain over the pressure area had been conducted since 9/15/13. Review of the medication administration record for September and October 2013 revealed that Ultram 50 mg had been administered for pain on 9/1/13 and 10/21/13; and Acetaminophen 650 mg had been administered on 10/29 and 10/31/13.	F 309	the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: ~~1/10/14~~ 12/11/13 approved phone DOH	

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F 309	Continued From page 13 During interview with registered nurse (RN)-A on 10/31/13 at 12:04 p.m., RN-A stated pain assessments were completed quarterly. RN-A also stated that when a resident complains of pain, a 24 hour log would be initiated and pain monitored and if a PRN medication was necessary, it was documented on the medication administration record (MAR) for staff to monitor the resident for continued pain or relief. RN-A verified the Wound Tracking forms lacked documentation to indicate that R4's pain had been monitored. She confirmed the expectation would have been to assess the pain status at the time the stage 1 pressure ulcer had been initially noted and ongoing thereafter so R4 could get optimal relief. During interview with nursing assistant (NA)-A, who regularly worked with R4, on 10/31/13 at 1:15 p.m., NA-A verified R4 complained of right hip pain occasionally. R41 and R10 were not been provided with positioning care to maintain proper body alignment while seated. R41's record was reviewed. Diagnoses identified included: stroke with right sided weakness, decreased right shoulder mobility related to a rotator cuff injury, pneumonia and dysphagia (difficulty swallowing). A quarterly MDS dated 8/13/13, identified that R41 was severely cognitively impaired, required extensive physical assistance from two staff for mobility and that R41 required limited physical assist of one staff for eating. On 10/29/13 at 8:57 a.m., R41 was observed to be seated in a geriatric (geri) chair at a table in	F 309		

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F 309	Continued From page 14 the dining room. R41 was observed to be slouched down, leaning back in the chair at approximately a 45 degree angle. Staff who served R41 her meal did not realign and/or reposition R41, but left her alone to eat breakfast. On 10/30/13 at 12:16 p.m., R41 was observed to be seated in the geri-chair at the table in the dining room. Because R41 had slid down in the geri chair, the edge of the table was noted to be at R41's mid-chest level. R41 was not repositioned by staff. On 10/31/13 at 9:08 a.m., R41 was again seated at the table in the dining room for breakfast. R41 was again noted to have slid down in the geri-chair and the table edge was nearly level with her chin and the upper chest area. RN-C and trained medication aide (TMA)-B were seated on opposite corners at the same table as R41. When the surveyor intervened, and asked RN-C to evaluate R41's positioning, RN-C stated, "Oh yeah, she needs to be boosted." RN-C removed R41 from the dining area and upon return, R41 was positioned upright in the geri-chair. At 9:20 a.m. on 10/31/13, RN-C stated R41 had been utilizing the geri-chair since a hospitalization a few months prior, because staff had felt R41 would be unsafe in a regular wheelchair. During interview on 10/30/13 at 2:00 p.m., nursing assistant (NA)-A confirmed R41 had begun using the geri chair following a hospitalization because of the fear she would fall out of a regular wheelchair. During interview on 10/31/13 at 12:24 p.m., RN-A was interviewed. RN-A stated the NA's had switched R41 from the wheelchair to the	F 309		

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F 309	Continued From page 15 geri-chair following a hospitalization. R10 was observed during the noon meal on 10/28/13 from 12:21 p.m. until 12:38 p.m.. R10 was observed seated in a geri-chair at a dining room table with NA-C assisting R10 during the meal service. R10 was observed to require total assistance with eating and was positioned with her body leaning to the left side of the geri chair on a pillow, head tilted forward, with her chin towards her chest, and feet dangling without touching the floor. NA-C was observed to have to hold R10's forehead upward, in order to feed R10. At 12:30 p.m., NA-C was observed to converse with RN-E, who adjusted R10's geri-chair to a slightly reclined position so R10's feet were elevated and supported by the foot rest. The position change made it so R10 did not lean as far forward in the geri-chair and staff did not have to tilt R10's head back in order to feed her. R10 was continuously observed in the dining room on 10/30/13 from 6:19 p.m. until 6:42 p.m. during the evening meal. R10 was observed seated in the geri-chair in an upright position. R10's head was leaning toward the left shoulder, with her upper trunk leaning forward in the chair. R10's feet were observed to be dangling without touching the floor, as the footrest had not been engaged. NA-B was observed to provide assistance with the evening meal by placing the palm of her right hand on R10's forehead in order to feed R10. NA-B did not attempt to reposition R10 during this meal observation, except to tilt the head up/down with her hand. R10 was observed on 10/31/13 at 8:49 a.m. the dining room during the breakfast meal. R10 was observed seated in the geri chair with her head and upper body tilted toward the left side of the	F 309		

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F 309	Continued From page 16 chair and her head tilted forward toward there chest even though a pillow had been placed on on either side of R10's body in the geri chair. In addition, the footrest of R10's chair had not been utilized and R10's feet were observed to dangle without touching the floor. R10 sat this way until 9:00 a.m. when NA-A repositioned R10 by adjusting the pillows in the geri chair. Even so, although R10 was sitting upright and centered in the chair, R10's upper body (head/shoulders) continued to lean forward with her head tilted downward and her chin resting towards her chest. R10's feet continued to dangle, without touching the floor as no support had been provided with the use of the footrest. Continuous observations were made until 9:34 a.m. During the observation, it was noted that NA-E and RN-C assisted R10 throughout breakfast, until 9:34 a.m. Neither were observed to realign/reposition R10 to provide/enhance proper positioning. According to record review, R10 and had diagnoses that included Lewy body dementia and Parkinson's disease. The MDS assessment dated 9/11/13, indicated that R10 had functional limitation in range of motion in both the upper and lower extremities on both sides of the body. The undated plan of care indicated R10 required total assistance of 1 with eating and total assistance of 1 with the geri chair. When interviewed on 10/29/13 at 10:06 a.m., R10's family member reported frustration when staff had not positioned R10 comfortably. The spouse stated during visits with R10, the resident isn't centered in her chair, is leaning too far to one side, and the footrests aren't always used which leaves her feet dangling.	F 309		

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F 309	Continued From page 17 When interviewed on 10/31/13 at 11:10 a.m., RN-A confirmed that R10 was sometimes positioned poorly during meal observations. RN-A stated she could not recall whether an assessment related to proper positioning in the chair had been conducted, stating she had been in the geri chair for "years". RN-A confirmed that R10's feet should not be dangling when in the geri chair and that her head should be positioned at an angle more conducive to eating without staff having to manually lift up her head. At the completion of the interview, RN-A requested an OT assessment be conducted to assure proper positioning for R10. During an interview on 10/31/13 at 1:10 p.m., OT-A stated that R10 would benefit from rolls or lateral supports in the geri chair to better support the body alignment in an attempt to assist with proper seating in the geri-chair. OT-A confirmed that R10's positioning could be improved. Skin bruising noted for R13 and R49 had not been monitored/assessed so that casual factors could be determined and appropriate interventions developed to prevent further injury. R13 had diagnoses that included multiple sclerosis (MS) and long-term use of aspirin. During an observation on 10/28/13 at 12:07 p.m. it was noted that three small bruises were evident on the dorsal (top) of R13's right hand. The bruise on the top of her right knuckle had a small V-shaped tear on it with a small steri strip over it. The remaining two bruises were approximately 1 centimeter (cm) in diameter. During this observation R13 stated, "the door bumps me or I bump the door". On 10/31/13 at 7:35 a.m. R13 stated, "I bump my hand on the door. I don't get out of the way quick enough". It was observed	F 309		

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F 309	Continued From page 18 that R13 was able to propel the wheelchair independently. R13 was observed on 10/31/13 at 9:14 a.m., to reach for the wheel of the wheelchair, and to propel herself with the use of the wheels, hitting the brake lever handles with the top surface of her hands as she propelled herself. The brake lever handle extended high enough to interfere with R13's ability to propel the wheelchair down the hall. As R13 wheeled into the lounge to view television, two new small bruises were observed on her left arm and the top of the hand. Review of nurses' notes through 10/28/13, indicated a lack of documentation related to skin issues as did the Wound Tracking form located in the skin assessment book referencing skin issues. The medication administration record (MAR) lacked any documentation related to recent bruises. Review of the current plan of care lacked any mention of skin related issues or bruising risk. The only documentation related to bruising was noted on the trauma report form dated 6/21/13 in which four bruises had been identified on each wrist by the bath aide during the spa. Interview on 10/31/13 at 10:25 a.m. with RN-A revealed that small insignificant bruises are tracked weekly at bath time (spa) using the spa notes and significant bruises were tracked daily using the MAR. RN-A verified the bruising on the dorsal aspect of the R13's right hand and the bruising on the left hand and forearm. Documentation was lacking to indicate the causal factors had been assessed so that interventions could be implemented to prevent and/or reduce the number of bruises identified on R13.	F 309		

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary grooming needs for 1 of 3 residents (R45) who was dependent on staff for grooming needs. Findings include: It was noted that R45 had a legally blind diagnosis. The Brief Interview for Mental Status (BIMS) indicated that R45 had severe cognitive impairment. During observation on 10/29/13 at 10:42 a.m., R45 was observed to have approximately 15 chin hairs of various length (1/4 inch to 1/2 inch). When interviewed about the chin hairs R45 touched her face and stated, "I don't like them but they won't let me have any scissors. I suppose I should ask someone". During an interview on 10/29/13 at 6:40 p.m., registered nurse (RN)-B verified the nurses' notes documented that R45's shower had been given on 10/29/13. RN-B further indicated that grooming occurred at the time of the spa bath. When interviewed on 10/29/13 at 6:50 p.m., licensed practical nurse (LPN)-B verified the chin	F 312	F312 R45 has been receiving proper grooming services, including the shaving of chin hairs. It remains an expectation that grooming services be completed accurately as needed on a daily basis, including the services provided during the spa for all residents. The spa services checklist has been revised to include shaving, as needed, for all residents, regardless of gender. The Director of Nursing and her designees (i.e. the charge nurse and LPN) will continue to be responsible for ensuring that they visually inspect residents to verify that the cares reported as completed on the spa/bath sheets matches what they can physically observe. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: 1/10/14 12/11/13 approval DON	

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F 312	Continued From page 20 hairs were present on R45 stating, "Yes, I see the chin hairs. I will take care of that for her". Although, staff had indicated the chin hairs would be removed, it was again observed on 10/30/13 at 6:34 a.m., and on 10/31/13 at 8:31 a.m., that the chin hairs were present and noticeable. Review of the care plan and the minimum data set assessment dated 7/26/13, indicated that R45 required extensive assistance (1 staff) for activities of daily living (ADLs) needs.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to coordinate care with the dialysis unit to promote the healing of a pressure ulcer for 1 of 3 residents (R4) reviewed who had a pressure ulcer. Findings include: Coordination of care between the dialysis unit and the facility had not occurred to prevent the	F 314		

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F 314	Continued From page 21 worsening and/or promote the healing of a recent identified pressure ulcer for R4. R4 had diagnosis which included chronic kidney disease and dialysis. R4 received dialysis three days a week for approximately 3 hours at a time. During interview with R4 on 10/29/13 at 10:18 a.m. R4 stated that his right hip hurt due to a "bed sore there". He indicate the staff "doctor" it, the sore hurts and keeps him awake at night. He also stated that he's never been encouraged to turn on his side. During a follow-up interview with RN-A on 10/30/13 at 12:30 p.m., it was stated the area was just a lump and RN-A did not think the area was open. She indicated that R4 had an appointment with the physician later that afternoon. After R4 had returned from the clinic, the skin area was observed with the registered nurse (RN)-A on 10/30/13 at 4:00 p.m. It was noted the upper right buttock area had a pink foam dressing. RN-A removed the dressing and a large amount of dark brown drainage was present on the dressing. The area located on the right buttock was approximately the size of a quarter and appeared to be a stage 2 pressure ulcer. A significant change MDS dated 8/28/13 identified R4 as being at risk for pressure ulcer. R4 was identified as needing extensive assistance of two persons in bed mobility and extensive assistance of one person for transfers. The CAA dated 8/23/13 identified risk for pressure ulcer related to R4 needing assistance with bed mobility, medication use, diagnosis, a history of weight loss, intermittent pain and decreased	F 314	F314 The Dialysis Unit has received information about R4's pressure ulcer, its healing progress, and the need for pressure relieving measures to be followed during his dialysis treatment. The packet of information sent to dialysis has been updated to include the pressure ulcer assessment sheet, the current treatment and a note from the Charge Nurse noting the progress and pain medications/management issues. The Director of Nursing and her designee will remain responsible for ensuring compliance. They will audit the new system for accuracy for six months, reporting their findings at the Quality Assurance meeting. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: ~~1/10/14~~ 12/11/13	

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

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F 314	Continued From page 22 communication. No referrals were recommended as R4 did not have any pressure ulcers. The plan was to continue with the bed and w/c (wheelchair) cushions, assist the resident with bed mobility as needed and to monitor and treat early signs or symptoms of skin breakdown or irritations and encourage adequate nutritional intake. Documentation on the wound tracking form identified that R4 had a stage 1 pressure area identified on the following dates: (1) on 9/1/13 a stage 1 pressure ulcer had been noted to the upper right buttock, and measured 5 centimeters (cm) by 1 cm, appeared red in color, not open and R4 had identified pain to the area; (2) 9/7/13- stage 1, measured 2 cm x 1 cm, red in color, not open and R4 identified pain to the area; (3) on 9/15/13 -a stage 1 on the right upper buttock, measured 3 cm x 1 cm, red in color, not open and pain had been identified by R4; and (4) on 10/19/13- stage 1 pressure ulcer, measured 0.3 cm x 0.4 cm, pink in color, not open and a Polymem dressing applied. Review of the care plan updated on 10/24/13 identified a stage 1 pressure ulcer on the right upper buttock ulcer and interventions included: monitor daily, apply Polymem dressing for protection, air mattress to bed, cushion to w/c (wheel chair) and encourage change in position. Documentation was lacking on the plan of care to indicate that interventions had been coordinated with the dialysis unit related to the presence of a stage 1 pressure ulcer which had been noted on 9/1/13. After R4 had been evaluated by the physician on 10/30/13, documentation on the MEDICAL	F 314		

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F 314	Continued From page 23 INFORMATION EXCHANGE FORM identified the reason for the referral as: "L (left) hip sore. The physician identified a stage 2 pressure ulcer and treatments as wound care and pressure pillow for chair. Review of the nurses note on 10/30/13 states that "resident seen by Dr. for the sore on his left hip. Wound diagnoses as stage 2 pressure ulcer. Order received: Pillows on chair. Follow wound care protocol. After return resident wound assessed and Polymem applied. Will change to duoderm at next change." Nursing documentation dated 10/30/13 noted that the stage 2 pressure ulcer measured 0.4 cm x 0.7 cm and 0.3 cm deep, had no drainage, no odor or undermining. Interview with RN-C on 10/31/13 at 2:40 p.m. revealed that she did not think the dialysis unit had ever been notified of the stage 1 pressure ulcer on the right upper buttock. Interview with dialysis RN-D on 11/1/13 at 9:15 a.m. confirmed the dialysis staff had not been informed of the stage 1 pressure ulcer nor that it had opened and been identified as a stage 2 on 10/30/13. She stated the dialysis unit would not have been aware of this issue, unless notified, which they had not been made aware. During interview with RN-A on 10/31/13 at 11:46 a.m., it was indicated that she thought staff had placed the Polymem dressing on the area for protection. RN-A confirmed the dialysis staff should have been made aware of the pressure ulcer so that appropriate interventions could have been implemented and coordinated to prevent further skin breakdown and promote healing.	F 314		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 24 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services as recommended by occupational therapy (OT) for 1 of 3 residents (R10) reviewed with limited ROM. Findings include: R10 had diagnoses which included dementia with Lewy bodies, osteoporosis and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 9/11/13, indicated R10 had long and short term memory problems, had severely impaired decision making skills, had functional limitation in ROM of bilateral upper and lower extremities and required total assistance from staff for all activities of daily living (ADL's). The plan of care with most recent revision on 9/30/13 included two areas related to R10's limited ROM as noted: (1) "ADL Maintenance/Rehab/Restorative-Assistance need r/t (related to) Levy [sic] body Dementia with severe cognitive impairment. Other risk factors included: generalized weakness/debilitation,	F 318	F318 R10 expired on 11/19/13. Currently, ten (10) other residents are receiving ROM services. We will continue to follow the system of identifying the need for ROM services for residents who experience declining ROM and exercise programs will be assigned by the RN Unit Coordinator. The services will continue to be documented on the treatment sheet and verified by the charge nurse or LPN daily. The Director of Nursing and her designee will continue to be responsible for ensuring that the services are provided and documentation accurately reflects this. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: 1/10/14 12/11/13	

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F 318	Continued From page 25 tremors, short and long term memory impairment, decreased communication, other diagnosis including Parkinson's disease, decreased ROM in the extremities and partial loss of voluntary movement with the Parkinson's disease". Interventions included: ROM to wrist, fingers and ankles 10 repetitions two (2) times a day". (2) " Disease/Diagnosis-Parkinson's disease-as evidenced by tremors esp (especially) on the upper extremities, use of medication, decreased ROM and voluntary movement..." Interventions included: "Provide passive ROM to all extremities, 5 repetitions 2 times a day after meals". Review of the August 2013 through November 2013 ADL sheets [cares completed by the nursing assistants (NA)] included, "ROM to arms & legs" indicating "AM" and "PM" in reference to frequency of implementation. Review of the most recent OT assessment dated 7/13/10, a problem list included: bilateral hand and feet contractures, total dependence with ADL's and with transfers. The functional level/discharge portion of the assessment had documented: "Nursing was instructed to complete PROM (passive range of motion) to bilateral extremities including wrists, digits & (and) ankles. ROM was instructed to be completed 2 x/day (two times a day) x 10 repetitions each. No further OT is needed at this time." During an interview on 10/30/13 at 7:20 p.m., (NA)-B confirmed that she and registered nurse (RN)-A had assisted R10 with bedtime cares. NA-B further verified that PROM had not been performed other than the movements of R10's arms and legs while getting her ready for bed and during positioning.	F 318		

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F 318	Continued From page 26 During an interview the following morning, on 10/31/13 at 11:10 a.m., RN-A confirmed that PROM had not been performed the previous evening (10/30/13) during bedtime cares when she had the assistance of NA-B. It had not been completed as stated on the plan of care. During an interview on 10/31/13 at 12:32 p.m., NA-F indicated that PROM had been performed during morning cares to R10's upper and lower extremities. As NA-F described the PROM, she stated that she usually will perform 3 or 4 repetitions to R10's arms and legs, or "maybe 5", as R10 is "really stiff"; NA-F further stated "it hurts her". NA-F also indicated that if R10 was really "stiff", she wouldn't perform as many repetitions. During an interview the following day, on 11/1/13 at 9:41 a.m., NA-F stated PROM would be performed during morning cares and bedtime cares when she had been scheduled either the early/late shift. NA-F described the PROM as the following: (1) bend R10's forearm up and down at the elbow and (2) bend the legs at the knee. NA-F confirmed she does not perform PROM to the hands and fingers. NA-F further stated that R10's feet are really stiff and point down so she doesn't do a lot with them, indicating the number of repetitions performed vary from day to day based on the status of R10. NA-F stated she will usually do 3-4 repetitions on each side and sometimes R10 will say "ouch" out loud or will grimace while PROM was performed. She had been unaware if R10 had required any specific exercises. NA-F was unaware whether R10 received any pain medication prior to PROM being performed. and indicated she had been employed for only 2 weeks.	F 318		

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F 318	Continued From page 27 During an interview on 11/1/13 at 9:53 a.m., NA-A also confirmed that PROM would be performed during morning and bedtime cares for R10. NA-A stated she provided PROM to R10's fingers, wrists, arms, legs, feet and ankles. NA-A revealed the frequency of PROM had been relative to "Whatever she can tolerate". NA-A stated if R10 would grimace, pull away or say "don't do that", the nurse would be notified. NA-A was unaware whether pain medication had been administered prior to PROM. During an interview on 11/1/13 at 11:42 a.m., RN-A confirmed the NA's were to perform PROM to all of R10's extremities which would include the wrists, fingers, and ankles. RN-A further confirmed the plan of care had been confusing as to the number/frequency of repetitions when providing PROM. RN-A stated the expectation would be for staff to perform 5 reps twice daily, or "Maybe 2-5". When questioned whether 5 repetitions vs. 10 repetitions would be appropriate per the recommendations from OT, RN-A shrugged and did not respond. RN-A confirmed the most recent OT evaluation had been 7/13/10 and was unable to indicate whether the recommendation from OT had changed. RN-A further confirmed the newly hired NA's had not been trained on PROM expectations for R10 nor had any instructional information been provided that defined which extremities were to be exercised, including the number of repetitions. The policy titled, "Rehabilitative and Restorative Program Policy", includes: "All nursing personnel are provided with the appropriate education to perform their assigned responsibilities....Rehabilitative, restorative, and	F 318		

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F 318	Continued From page 28 supportive nursing services include the following:...active and passive range of motion exercises....Residents are assessed and needs addressed in the Plan of Care on admission...Evaluation of care and readjustment of goals occur in a timely manner."	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that staff checked for proper tube placement prior to the	F 322	F322 An in-service was provided to all RNs and LPNs on 11/22/2013 to review the procedure for administering medication through a PEG tube for R20. The in-service included the proper way to check placement for the PEG tube before giving medications. To date, R20's PEG tube is not being used for medication administration nor for nutrition. It is flushed and placement checked daily. The Director of Nursing and her designee will continue to be responsible for ensuring that training is provided, especially to new employees, and the process is followed accurately. Correction Date: 11/25/13	

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F 322	Continued From page 29 administration of medications for 1 of 1 resident (R20) who had a gastrostomy tube. Findings include: R20's diagnoses included history of oral cancer, malnutrition and swallowing difficulty. R20 received medications through a gastrostomy (G-tube) or stomach tube. During medication administration observation on 10/31/13, at 8:31 a.m., licensed practical nurse (LPN)-A prepared Aspirin, Metoprolol, and two multivitamins by crushing them and dissolving them in water. LPN-A flushed the G-tube initially with water and then administered each medication with water flushes in between. LPN-A did not check for placement of the G-tube prior to the administration of the water and the dissolved medications. When interviewed on 10/31/13, at 9:05 a.m., LPN-A confirmed the placement of the G-tube had not been checked prior to the administration of the medications. LPN-A further indicated that she had never routinely checked placement of R20's gastrostomy tube. LPN-A was unsure of the facility's policy and procedure for checking placement prior to the administration of medication. On 10/31/13, at 12:24 p.m., registered nurse A (RN)-A indicated it had been a standard of practice to check for proper placement of a G-tube prior to the administration of medications as that had been the practice she had implemented. During review of policies: The Enteral Tubes Adult and Pediatric: Administering Enteral Nutrition; Flushing Enteral Tubes; and Administering Medications- they lacked direction on checking placement prior to administering medications.	F 322		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 30 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately assess the need for a medication prescribed for sleep, and failed to ensure adequate monitoring was completed to determine the effectiveness of the medication for 1 of 1 (R57) resident reviewed who received a medication for sleep.	F329	F329 Progress notes for November and December 2013 do not indicate that R67 has reported trouble sleeping at night. Record review also indicates that he started receiving a scheduled pain med on 10/29/13 which may also account for relief from insomnia. The continued use of trazodone will be assessed by the consulting pharmacist in January to determine if his relief from insomnia is due to the medication. Non-pharmacological approaches to consider in the future were noted on 9/6/13 in a social service progress note which discusses R67's home routine of drinking bourbon in the evenings. He also indicated that he used Tylenol PM when he couldn't sleep. This information will be supplied to the consulting pharmacist as well. The interdisciplinary care team will continue to discuss possible interventions, which include non-pharmacological approaches, when addressing insomnia. The Director of Nursing will continue to be responsible for ensuring that the plan of care is backed up by an assessment and that the care plan accurately reflects what is being provided.	

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F 329	Continued From page 31 Findings include: R57 had diagnoses including: anxiety and depression. Review of the resident's record indicated the resident had been seen for a routine visit with the physician on 9/12/13, and had requested a sleeping pill. The physician had prescribed Trazodone 50 mg (milligrams) (an antidepressant sometimes used to induce sleep) 1 po (orally) at HS (bedtime), and had documented a diagnosis of insomnia. The medication administration record (MAR) from September 2013 through October 31, 2013 indicated R57 had received the Trazodone as prescribed every day since it had been ordered. . Additional review of the medical record identified a lack of documentation of any non-pharmacological interventions or alternative approaches attempted to help the resident with sleep. In addition, the medical record lacked documentation to indicate the medication was monitored and/or periodically assessed for effectiveness. During an interview with the nursing supervisor on 10/31/13 at 12:12 p.m., she verified that a sleep assessment had not been completed. The nursing supervisor stated, "I guess since we didn't do an assessment we won't know if the medication is helping or not." She further stated that the resident's family had taken him to the doctor on 9/12/13, and had reported R57 was not sleeping. At that time the physician had ordered the Trazodone for sleep. However, the physician visit sheet indicated a licensed practical nurse from the facility had documented the reason for referral visit as, "Resident is requesting sleeping	F 329	The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: 1/10/14 12/11/13 approved done DON/Admin	

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F 329	Continued From page 32 pill, states he took Tylenol PM at home."	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 Re-training was provided to personnel who administer medications and provide treatments (e.g. nebulizers, glucochecks), emphasizing the steps that would prevent the spread of infection. The DON added the provision of hand sanitizer in the pockets of all staff to be used in addition to handwashing. The Director of Nursing or her designee will audit medication passes at least monthly for six months and results reported at the Quality Assurance meeting, especially focusing on how the personnel adhere to infection control procedures. The audit may also be performed by the pharmacy consultant. The Summary of Deficiencies was dated 12/13/13 and received by this facility on 12/18/13. It was not possible for this facility to be in compliance 40-days after the Exit Date because we did not know the full extent of the deficiencies cited. Proposed correction Date: 1/10/14 ~~1/10/14~~ 12/11/13 approval DNS	

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F 441	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow proper infection control techniques including handwashing and equipment cleansing, during observations of medication administration for 4 of 10 residents (R18, R20, R29 and R41), and during observation of glucometer blood sugar checks for 4 of 4 residents (R4, R16, R41 & R44) who had glucometer blood sugar monitoring conducted. Findings include: During a medication administration pass on 10/31/13, from 7:37 a.m. until 9:00 a.m., licensed practical nurse (LPN)-A was observed to punch out four separate oral medications (Sinemet, Aspirin, Metoprolol, and multivitamin) for R20 and R29 from multi dose bubble packs into her bare hands and then into medication cups. Also during the medication pass, LPN-A was observed to administer nebulizer treatments for R18 and R41. After entering each resident's room, LPN-A opened up the nebulizer reservoir and dumped out the remaining liquid from the prior administration before pouring the new medication into the reservoir. Upon completion of the nebulizer treatment, LPN-A left the mask and reservoir intact on the bedside stand. LPN-A failed to rinse out the reservoir at any time and/or leave the reservoir open to dry. During interview with LPN-A at 9:05 a.m. on 10/31/13, LPN-A confirmed she should not have touched the residents' medications with her bare hands, but should instead have punched the medications directly into the appropriate medication cups. Further, LPN-A stated it was her	F 441		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING _____ B. WING _____	11/01/2013

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

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F 441	Continued From page 34 usual practice to leave the nebulizer equipment sealed together, and verified she did not routinely rinse the equipment after use. LPN-A stated she thought that rinsing the reservoir out after use would increase the risk of germs getting into the container. During interview with registered nurses (RN)-A at 12:24 p.m. on 10/31/13, RN-A confirmed that touching medications with bare hands was not an acceptable practice, and that nebulizer reservoirs were supposed to be rinsed out and left to dry after each use. During interview on 11/1/13 at 10:14 a.m., the RN-G, the facility's infection control nurse, confirmed the nebulizer reservoirs should be rinsed out and turned upside down to air dry on a clean paper towel after each use. The facility's Medication Administration policy was reviewed. The policy did not specifically address nebulizer treatments or how to handle oral medications. On 10/31/13 at 7:20 a.m., LPN-A was observed to perform an accucheck (use of a fingerstick device for blood glucose monitoring) for R16. Although LPN-A had worn gloves during the procedure, after completion of the procedure LPN-A removed the gloves, left the room, and deposited the used lancet into a Sharps container (a container for hazardous sharp utensil disposal). LPN-A had then stated, "I suppose I should wash my hands." However, without handwashing, LPN-A proceeded to remove medications she'd previously set up for R44 from the medication cart and entered R44's room. When asked if she had washed her hands, LPN-A replied, "I didn't do that and I should have". LPN-A stated that handwashing following the removal of gloves after an accucheck would have been her routine	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING _____ B. WING _____	11/01/2013

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

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F 441	Continued From page 35 practice. On 10/31/13 at 7:46 a.m., trained medication aide (TMA)-A was observed to perform an accucheck on R4. TMA-A donned gloves, advised R4 of the procedure and completed the accucheck. After completion, TMA-A removed her gloves, disposed of them in the garbage and left R4's room. TMA-A then disposed of the used lancet into a Sharps container. TMA-A then sanitized the glucometer machine and without washing her hands, TMA-A proceeded to set up medication for R41 at the medication cart. When questioned regarding the proper handwashing practice after completion of an accucheck, TMA-A stated she should have washed her hands, "after I removed my gloves, I didn't do that". During an interview on 11/1/13 at 10:14 a.m., (RN)-G stated that staff were expected to wear gloves while performing an accucheck and that handwashing should occur after the removal of the soiled gloves, which would occur after the accucheck had been completed. RN-G further stated that if staff had not visibly soiled their hands, an antibacterial cleanser rather than washing hands with soap and water would be acceptable. RN-G stated, "It is our policy". The facility's Hand Hygiene Policy was reviewed. According to the policy, "Gloves are removed when the need for protection no longer exists and hand hygiene should be practiced immediately after removal of gloves."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/11/2013**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 11, 2013. At the time of this survey, Mayo Clinic Health System Fairmont was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Mayo Clinic Health System Fairmont was constructed as follows: The original building was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction; The 1990 building Addition is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 33 at time of the survey.	K 000		

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

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.