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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QDJW

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 **03/19/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 03/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/07/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/27/2015
(L33)

DETERMINATION APPROVAL

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

CCN 24-5274

On March 19, 2015, the Minnesota Department of Health completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on February 20, 2015. We presumed, based on the plan of correction, that this facility had corrected these deficiencies as of February 20, 2015. Based on our visit, we have determined that this facility has corrected the deficiencies issued pursuant to our PCR, completed on February 20, 2015, as of March 19, 2015. As a result of the revisit findings, the Department is:

--Discontinuing the Category 1 remedy of state monitoring effective March 19, 2015.
--Rescinding mandatory denial of payment for new Medicare and Medicaid admissions, effective March 19, 2015.

NATCEP prohibition is rescinded. Refer to the CMS 2567b.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245274

March 27, 2015

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.

Effective March 19, 2015 the above facility is certified for or recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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

Electronically delivered

March 26, 2015

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

RE: Project Number S5274024

Dear Ms. Campbell:

On March 5, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 8, 2015. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on December 19, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on February 20, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 19, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on February 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 20, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 20, 2015, as of March 19, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 19, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 5, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 19, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 19, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 19, 2015, is to be rescinded.

In our letter of March 3, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 19, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 19, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245274	A. Building B. Wing	3/19/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	03/19/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	03/19/2015	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	03/19/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	03/25/2015	22113	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2014			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

Electronically Delivered

March 26, 2015

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

RE: Project Number S5274024

Dear Ms. Campbell:

On March 19, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on March 19, 2015, imposed a daily fine in the amount of $ 350.00.

On March 19, 2015, a written notification was received by the Department stating that the violation(s) had been corrected. A reinspection was held on March 19, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is attached.

Therefore, the total amount of the assessment is $ 350.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $ 232.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $ 582.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

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

cc: Licensing and Certification File
Cathy Serie, Mankato District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QDJW

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 **02/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 03/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/27/2015 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/27/2015
(L33)

DETERMINATION APPROVAL

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

CCN 24-5274

On February 20, 2015, the Minnesota Department of Health completed a revisit to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2014. Based on our visit, we have determined that this facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 19, 2014. The deficiencies not corrected are as follows:

F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiencies:

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0520 -- S/S: E -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in this facility were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G). Please refer to the CMS 2567 and 2567b.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

March 3, 2015

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

RE: Project Number S5274024

Dear Ms. Campbell:

On January 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 20, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 19, 2014. The deficiencies not corrected are as follows:

F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiency(ies):

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0520 -- S/S: E -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective March 8, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 19, 2015 remain in effect. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 19, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 19, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Mayo Clinic Health System - Fairmont is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective March 19, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division

Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 June 19, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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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	2/20/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **01/28/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/28/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/28/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/28/2015**	ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **01/28/2015**	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	03/05/2015	28591	02/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 2/19/15 and 2/20/15. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
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	F 280		3/13/15

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

Electronically Signed | 03/13/2015

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

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F 280	Continued From page 1 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 and update the care plan for 3 of 3 residents (R29, R7 and R19) reviewed who had facility acquired pressure ulcers. Findings include: R29 was admitted on 12/11/12 and current diagnoses listed on the care plan included: atrial fibrillation, cerebrovascular disease, peripheral vascular disease (PVD) and hypertension. On 2/19/15, at 12:05 p.m. R29 was identified by the director of nursing (DON) to have a stage 2 pressure ulcer (PU) on the outside right ankle region which was acquired (1/6/15)while at the facility. During observation of morning cares on 2/20/15, at 6:46 a.m. NA-A removed a long body pillow from behind R29's back, which had maintained her in a right side lying position. During the observation staff removed R29's blanket from her foot region and the right foot and ankle area was noted covered with gauze. There was no evidence of a foot boot when the covers were removed. When staff were questioned about the location of the boot, NA-A pointed on top of R29's clothing cabinet and the boot was on top of	F 280	This plan and response to these survey findings is written solely to maintain certification in the Medicare and Medical Assistance Programs. These written responses do not constitute an admission by Mayo Clinic Health System-Fairmont of noncompliance with any requirement nor an agreement with any finding. Mayo Clinic Health System-Fairmont reserves its right to dispute these findings in their entirety at any time and in any legal action. Mayo Clinic Health System-Fairmont may submit a separate request for Informal Dispute Resolution for certain findings. F280 The care plan for R29 was updated on 2/20/2015 by the MDS Coordinator to reflect the current PU on the right outer ankle, including information under the category of "problem" stating, "likes to lay on right side". The current interventions state: "Pressure ulcer care per doctor's orders, use of air mattress on her bed and w/c cushion with soft-backed w/c, check placement bid, monitor and treat early S&S of skin irritation and/or breakdown, encourage adequate nutritional intake,	

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F 280	Continued From page 2 the cabinet. NA-A stated R29 frequently kicked the boot off. It was also noted that R29's right ankle was resting on the mattress of the bed when in the right side lying position. During review of R29's medical record it was noted on a Wound Tracking Form that R29 was identified with a unstageable pressure ulcer located on the right outer ankle which measured 0.5 x 0.5 centimeters (cm) on 1/6/15. The Wound Tracking Form documentation identified the ankle wound continued to increase in size (1.0 cm) circumference and was identified as a stage 2 PU when last documented on 2/14/15. The care plan dated 1/20/15, identified that R29 was at risk for PU related to needing staff assistance with bed mobility, weight loss and at risk for pressure ulcers. Other risk factors included: needs assistance with all activities of daily living (ADLs), has cognitive impairment, decreased communication, intermittent pain, history of pressure ulcers, diagnosis and occasional urinary incontinence. Interventions identified on the care plan included: (1) encourage adequate nutritional intake; (2) offer 240 ml Ensure (supplement) twice daily; (3) monitor and treat early S&S (signs and symptoms) of skin irritation and or breakdown; (4) the use of air mattress on her bed; and (5) a use of a wheelchair cushion with soft backed wheelchair. The care plan was last revised/reviewed on 8/5/14 for PU risk and it failed to identify that R29 had an active pressure ulcer. Interventions were not evident on the care plan related to an individualized repositioning schedule, the identification of the type of treatment utilized nor that utilized a boot on her foot.	F 280	offer 240 mL Ensure bid, monitor pain and pain medications as ordered, keep skin clean and dry, barrier cream to areas exposed to incontinence, encouraging mobility, use of boot to keep pressure off (of ankle), reposition every two hours and PRN, and notify doctor if worsens or signs/symptoms of infection". The care plan for R7 was updated on 2/20/2015 by the MDS Coordinator to reflect the current PU on coccyx, below right buttock. In addition to following the doctor's order dated 2/21/15 of "below right buttock ulcer apply small amt aquacell and cover with mepilex bordered 4x4 foam change every 3 days et pm every 72 hours for pressure ulcer", the current interventions state: "follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor nutritional status. Serve diet as ordered, monitor intake and record, offer Juven supplement two times per day for wound healing, reposition every 2 hours and PRN, the resident requires bed and Navy blue w/c cushions, check placement bid." R7's PU was noted as healed on 3/7/2015. The care plan was updated to reflect interventions focusing on pressure ulcer prevention, including, "turn and reposition every 2 hrs, Juven tid, cushions in chair, and air mattress on bed". The care plan for R19 was updated on 2/20/2015 by the Charge Nurse to reflect current PU located on the "left lateral malleolus". The newest interventions ordered by physician were completed by the wound therapist on 3/11/2015.	

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F 280	Continued From page 3 During an interview on 2/19/15, at 1:02 p.m. the DON verified there had not been a revision nor update documented on the care plan to identify that any additional interventions that had been implemented since the identification of the pressure ulcer/wound which had increased in size. R7 admitted on 5/20/13 and had active diagnoses listed on the care plan which included: neurogenic bladder, history of foot ulcer, stage 2, multiple sclerosis (MS), history of low back pressure ulcer, history of buttocks pressure ulcer, malaise and fatigue. Review of R7's medical record revealed a Wound Tracking Form dated 2/7/15 identified R7 with a stage 2 PU. The form lacked documentation which identified the location of the PU but identified the wound size as a 0.8 cm x 2.5 cm open area with red drainage and a pink wound bed. There was no further documentation on any of the Wound Tracking Forms since 2/7/14 to monitor the progress of the PU, whether it had improved and/or worsened. During observation of resident cares on 2/20/15 at 5:57 a.m. R7 was observed lying on her bed on her back (supine position) with the bed in the low position. At 6:19 a.m. NA-A entered room to assist R7 out of bed and at 6:21 a.m. NA-C joined to assist with the transfer from bed with the use of an EZ stand mechanical lift. After completion of cares, at 6:24 a.m. NA-A and NA-C positioned R7 on the edge of her bed in seated position and attached the support belt from the lift swing to transfer R7 from the bed into the bathroom. When assisted from the toilet, it was observed	F 280	On 3/11/2015, the DON reviewed all residents for pressure ulcers. For those residents with a pressure ulcer or who are at high risk for skin breakdown, the DON reviewed the resident□s care plan to confirm that it reflects the pressure ulcer and/or the resident□s risk for skin breakdown and all current interventions. Nursing Practice and Education staff will provide education regarding the organization□s Pressure Ulcer Management and Treatment Policy□and, specifically, documentation of pressure ulcers, skin breakdown, and associated interventions in the resident care plan□to Lutz Wing RN staff on March 13, 2015. At this time, staff competency will be assessed via a test. By March 13, 2015, the Director of Nursing will also meet with all RN staff individually to review the organization□s Pressure Ulcer Management and Treatment Policy and set expectations regarding updating and documenting on resident care plans. The Director of Nursing, in conjunction with the MDS coordinator, will ensure that audits of all resident care plans and records for residents with pressure ulcers are completed weekly for six months, beginning March 13, 2015. Results will be reported out quarterly at Lutz Wing QA meetings, beginning with the April 15, 2015 meeting. After six months, the Director of Nursing, Nursing Home Administrator, and Nurse Administrator will reassess the need for further audits.	

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F 280	Continued From page 4	F 280	Completion Date: 3/13/2015	

that R7 had a 4 x 4 dressing applied to the right gluteal fold. When questioned whether the area was painful R7 stated, "It hurts when I sit too long but not right now".

R7's last revised care plan dated 1/19/15 failed to identify the gluteal fold PU (2/8/15) and failed to revise and modify any interventions related to the PU. This care plan identified that R7 would remain free of further skin breakdown and identified her at risk for PU development related to medications, ADL needs, bowel incontinence, decreased range of motion, pain and medical diagnosis. However, the care plan had not been revised and modified to reflect the current status of the resident.

During interview with the DON and RN-A on 2/20/15, at 8:10 a.m. it was verified the care plan had not been revised and/or modified.

R19 was admitted on 8/14/13 and had current diagnoses listed on the care plan which included: history of transischemic accident, hypertension, history of malignant neoplasm and dementia.

During review of R19's medical record it was noted there was a Wound Tracking Form initiated 1/20/15 which identified an unstageable PU measured 0.5 cm x 0.3 cm and located on the left ankle. The Wound Tracking Form was last documented on 2/14/15 which identified an unstageable PU on the left ankle.

During observation of a.m. cares on 2/20/15 at 7:30 a.m. NA-C and NA-R assisted R19 out of bed with the use of a EZ stand mechanical lift. R19 was noted to have a boot on her left ankle when staff uncovered her foot. NA-C stated R19

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F 280	Continued From page 5 was dependent of staff to turn and reposition and transfer out of bed. R19's care plan identified her at risk for PU related to needing extensive assistance with bed mobility and occasional urinary incontinence. Other risk factors for further skin breakdown included-needing assistance with her ADLs including bed mobility, diagnosis, cognitive impairment, needing assistance with her ADLs, decreased communication and , history of a pressure ulcer. The care plan failed to identify that R19 had a current pressure ulcer located on the left ankle (1/20/15) nor were there any revisions and modifications identified related to the current PU. During interview with the DON and RN-A on 2/20/15, at 8:15 a.m. neither staff could locate a physician order for the use of the Mepilex dressing for the wound. The DON verified verified the care plan had not been revised to reflect interventions to promote healing and prevent further skin breakdown of the identified PU nor had the current treatment plan been added to the care plan.	F 280		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	{F 314}		3/16/15

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{F 314}	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive reassessment when pressure ulcers were identified, failed to ensure staff monitored and provided care that promoted healing, and failed to develop measures to prevent further deterioration and reduce the risk of new pressure ulcers for 3 of 3 residents (R29, R7, R19) reviewed who had facility acquired pressure ulcers, and who all had a history of pressure ulcers. These deficient practices caused actual harm for R29 and R7. Findings include: R29 had a history of pressure ulcers and developed an unstageable ankle pressure ulcer on 1/6/15, which increased in size from 0.5 cm (centimeters) to 1.0 cm by 2/14/15. R29 did not receive the treatment as ordered by the physician, nor were interventions consistently implemented including a fleece boot to the affected foot. In addition, no comprehensive reassessment had been conducted and/or subsequent interventions developed, to promote healing and prevent further deterioration. This practice resulted in actual harm to R29. R29 was admitted to the facility on 12/11/12, and current diagnoses listed on the care plan included: atrial fibrillation, cerebrovascular disease, peripheral vascular disease and hypertension. R29's most recent quarterly Minimum Data Set	{F 314}	F314 On 3/12/2015, the Charge Nurse completed a skin integrity reassessment on the pressure ulcer on R29□s outer right ankle and documented the findings and contributing factors on the second page of the assessment tool. The Charge Nurse documented the existence of the pressure ulcer in R29□s care plan. The DON confirmed that the physician orders for the Tincture of Benzoin and fleece boot are part of the medical record and that direct care staff were instructed/trained on the implementation of the orders. The Wound Tracking form is expected to be updated with weekly entries. The Tissue Tolerance evaluation will be completed on 3/15/2015 which will assist in determining a repositioning plan for R29. The DON communicated all interventions, including the Tincture of Benzoin, fleece boot, individualized repositioning schedule, etc. to direct care staff and documented the interventions in R29□s care plan. The DON notified R29's family and physician regarding the status of the pressure ulcer on 3/12/2015. R7's PU was noted as healed on 3/7/2015. On 3/12/2015, the Charge Nurse completed a skin integrity assessment and documented the findings on the second page of the assessment tool. The care plan was updated to reflect	

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{F 314}	Continued From page 7 (MDS) assessment dated 1/7/15, indicated R29 required extensive assistance of one to two staff with bed mobility, transfer, mobility, dressing and toileting. The Brief Interview for Mental Status (BIMS) indicated R29 had a score of 12, indicating mild cognitive impairment. The assessment further identified that R29 had an unstageable pressure ulcer (PU) on her right outer ankle. During record review it was identified that R29 had a history of pressure ulcers which included a stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) located on her middle coccyx region which healed on 5/1/14. On 2/19/15, at 12:05 p.m. R29 was identified by the director of nursing (DON) to have a stage 2 PU on the outside right ankle region which was recently acquired (1/6/15) while at the facility. Nursing progress note documentation dated 12/4/14, identified that R29 complained of pain on the right outer ankle and staff discovered a 0.5 cm scabbed area with peripheral redness and a Polymer dressing had been subsequently applied to the area. There was no further documentation related to the red scabbed area identified in the medical record until 1/6/15, when the unstageable PU located on the right outer ankle was identified. During further medical record review it was noted on a Wound Tracking Form that R29 was identified with an unstageable PU located on the right outer ankle which measured 0.5 x 0.5 centimeters (cm) on 1/6/15. Documentation on the Wound Tracking Form identified the ankle PU continued to increase in circumference size (1.0 cm) and was documented as a stage 2 PU on 2/14/15. A nursing progress note dated 2/14/15,	{F 314}	interventions focusing on pressure ulcer prevention, including, "turn and reposition every 2 hrs, Juven tid, cushions in chair, and air mattress on bed". On 3/12/2015, the DON completed a skin integrity reassessment on the pressure ulcer on R19□s left outer ankle and documented the findings and contributing factors on the second page of the assessment tool and noted completion of the assessment in the nurses notes. The Charge Nurse documented the existence of the pressure ulcer in R19□s care plan. The Tissue Tolerance evaluation will be completed on 3/15/2015 which will assist in determining a repositioning plan for R19. The DON confirmed that the physician order for wound treatment and evaluation by the physical therapist was documented in the nurses notes and that the order had been implemented. The DON communicated all interventions as documented in the care plan and physician's orders to direct care staff. On 1/20/2015, the Charge Nurse notified R7□s family and on 2/25/2015 the physician was notified regarding the status of the pressure ulcer and the updated, individualized plan of care and interventions. The DON reviewed the Pressure Ulcer Management and Treatment Policy. The purpose of the policy is "to guide the care of pressure ulcers and to describe the process for pressure ulcer risk assessment and describe interventions for prevention of pressure ulcer	

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{F 314}	Continued From page 8 timed 12:56 p.m. identified that R29 had an open area on her right ankle that appeared red and swollen and measured as a 1.0 cm open area on ankle. The note indicated staff had reapplied a Mepilex dressing, doubled, with a cut open area, wrapped with kerlix and no further documentation since 2/14/15 entry. A Braden Scale assessment (tool used to determine risk for pressure ulcer development) was conducted on 1/7/15, which identified that R29 had a score of 17, indicating only a mild risk of developing pressure ulcers. However, the medical record lacked an assessment of the skin integrity and it's supporting structures to determine how long pressure can be on one area without ill effect. During an interview on 02/19/15, at 1:02 p.m. the DON stated there had been no comprehensive reassessment related to the PU/skin integrity for R29 and verified there had not been any revision documented on the care plan to identify that any additional interventions had been implemented since the identification of the pressure ulcer/wound which had increased in size. When interviewed on 2/19/15, at 1:24 p.m. nursing assistant (NA)-A stated R29 was toileted in the a.m. (morning) after getting up and after breakfast and then after lunch. NA-A further stated R29 repositioned herself so the staff did not reposition her unless she would request assistance even though the MDS identified R29 required staff assistance with bed mobility. When NA-B was questioned on 2/19/15 at 2:26 p.m., NA-B stated R29 required the assistance of one to two staff (extensive assist) or utilized the EZ stand lift (mechanical lift) at times for transfer and toileting needs. NA-B further stated R29 was	{F 314}	development." On 3/11/2015, a list of residents with current skin wounds was established. Their medical records were examined to confirm the presence of necessary skin integrity assessments, physician orders for treatment, wound tracking sheets kept current, and evidence that the protocol are being followed by direct care staff. All residents' skin integrity is assessed upon admission, quarterly, and with significant changes by an RN. Those who are at risk for skin breakdown due to the identified risk factors in the assessment are monitored more closely. An internal practice at the Lutz Wing will be added to the Pressure Ulcer Management and Treatment Policy to provide that a licensed nurse will conduct a skin integrity assessment of all residents at least weekly, ideally during the resident□s bath and document the assessment in the Nurse Progress Notes. Each resident□s skin has the potential to be monitored during daily cares by Nursing Assistants. They are instructed to inform the Charge Nurse of concerns. Negative developments with regard to a resident□s pressure ulcer will be communicated by the Charge Nurse to the resident□s treating physician and the family/responsible individual. Upon identification of a pressure ulcer, the Charge Nurse will conduct a skin integrity assessment to determine the severity of the pressure ulcer and appropriate interventions. The Charge Nurse will document the pressure ulcer and	

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{F 314}	Continued From page 9 routinely toileted before breakfast, after breakfast, after lunch, and in the p.m. (afternoon) and stated that R29 was repositioned when toileted. During observation of morning cares on 2/20/15, at 6:46 a.m. NA-A removed a long body pillow from behind R29's back, which had maintained her in a right side lying position. During the observation, staff removed R29's blanket from her foot region and the right foot and ankle area was observed to be covered with gauze. There was no evidence of a foot boot in place when the covers were removed. When staff was questioned about the location of the boot, NA-A pointed to the top of R29's clothing cabinet and the boot was observed on the top of the cabinet. NA-A stated R29 frequently kicked the boot off. It was also noted that R29's right ankle was resting on the mattress of the bed when positioned in the right side lying position. The care plan dated 1/20/15, identified that R29 was at risk for PU related to needing staff assistance with bed mobility, weight loss and at risk for pressure ulcers. Other risk factors included: needs assistance with all activities of daily living (ADLs), has cognitive impairment, decreased communication, intermittent pain, history of pressure ulcers, diagnosis and occasional urinary incontinence. Interventions identified on the care plan included: (1) encourage adequate nutritional intake; (2) offer 240 ml (milliliters) Ensure (supplement) twice daily; (3) monitor and treat early S&S (signs and symptoms) of skin irritation and or breakdown; (4) use of air mattress on bed; and (5) use of a wheelchair cushion with soft backed wheelchair. The care plan failed to identify that R29 had a current PU and no interventions were identified	{F 314}	interventions in the care plan. Upon receiving a physician order, nurse receiving the order will document the order in the Physician's Orders. The Charge Nurse will instruct the nursing staff of the instruction. If applicable, the nurse will transmit the order to the pharmacy. Nursing Practice and Education staff will provide education regarding the organization□s updated Pressure Ulcer Management and Treatment Policy to Lutz Wing RN staff on March 13, 2015. At this time, staff competency will be assessed via a test. By March 13, 2015, Director of Nursing will also meet with all RN staff individually to review the organization□s Pressure Ulcer Management and Treatment Policy and set expectations regarding implementation of pressure ulcer interventions and updating and documenting resident care plans. The Director of Nursing, or delegate, ensures audits of all resident records with pressure ulcers are completed weekly for six months, beginning March 13, 2015. Results will be reported out quarterly at Lutz Wing QA meetings, beginning with the April 15, 2015 meeting. After six months, the Director of Nursing, Nursing Home Administrator, and Nurse Administrator will reassess the need for further audits. Completion Date: 3/16/2015	

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related to an individualized repositioning schedule based on a comprehensive reassessment, the identification of treatments utilized, nor that a boot was supposed to be applied to the foot at night.

When interviewed on 2/20/15, at 7:30 a.m. registered nurse (RN)-A stated R29 had a physician order for use of a fleece boot at hour of sleep (HS) to prevent pressure. RN-A further stated R29 had a physician order dated 1/8/15, for use of Tincture of Benzoin and a thick corn pad applied over the PU located on the right outer ankle area. However, RN-A stated staff utilized a Mepilex foam dressing with the center cut out and applied gauze over the dressing. RN-A state the dressing was changed as needed and every 3 days. RN-A also verified there was no specific physician order for this particular treatment. RN-A verified she was unable to locate any comprehensive reassessment after discovery of the PU nor were there any PU interventions evident on the care plan. RN-A stated the charge nurse should have updated the care plan to reflect the condition of R29 and should have assessed the wound so that individualized interventions could be developed and implemented.
When interviewed on 2/20/15, at 7:40 a.m. charge nurse/RN-B stated that upon discovery of a PU, it would be measured and the family and doctor would be notified. RN-B stated a Wound Tracking Form would be initiated, the identification of the PU would be documented in the wound book, and the DON would also be notified. RN-B confirmed there had been no comprehensive reassessment completed related to all the risk factors for R29. RN-B acknowledged the only assessment conducted had been a Braden assessment which did not

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accurately reflect all the risk factors. RN-B also stated all residents are placed on a two hour repositioning schedule when a PU is identified to reduce the risk of further development. RN-B verified there had not been a reassessment conducted to confirm the 2 hour schedule was appropriate for R29 nor had a care plan been developed subsequent to the development of the PU located on R29's ankle.

Although the medical record identified that R29's PU located on the ankle increased in size from the initial measurement (dated 1/6/15) of 0.5 cm x 0.5 cm unstageable to a 1.0 cm x 1.0 cm PU dated 2/14/15, the facility failed to develop an individualized plan of care based on a comprehensive assessment to identify what interventions should be implemented or modified to help decrease the risk of R29 developing additional pressure ulcers and promote healing. There was no indication the pressure ulcer was consistently monitored. Further R29 had an order for the use of a boot on her right foot to protect her ankle and reduce pressure. Because staff had not routinely applied the boot due to R29's frequent removal of the boot, evidence was lacking to indicate interventions had been modified and re-evaluated for alternative approaches. In addition, facility nursing staff applied a Mepilex foam dressing to the ankle instead of the physician ordered Tincture of Benzoin with a thick corn pad. This practice resulted in actual harm to R29.

R7 had a history of multiple pressure ulcers (Stage 2 and Stage 3) located on the coccyx, and developed a recurrent coccyx ulcer on 2/7/15, without comprehensive reassessment and individualized interventions to promote healing

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and prevent further deterioration. Monitoring of the ulcer was lacking .This practice resulted in actual harm for R7.

R7 had been admitted 5/20/13 and had diagnoses listed on the care plan including: neurogenic bladder, history of foot ulcer, stage 2, multiple sclerosis (MS), history of low back pressure ulcer, history of buttocks pressure ulcer malaise and fatigue.

The quarterly MDS assessment dated 12/31/14, indicated R7 had a BIMS score of 6, indicating severe cognitive impairment. The MDS also indicated R7 required extensive assistance of two staff with bed mobility, transfers from bed and chair, and assistance of two with toileting. Documentation on the assessment identified that R7 had a stage 2 PU over a bony prominence.

Documentation on a Wound Tracking Form, dated 5/6/14, identified R7 had a stage 2 PU on the right gluteal fold region measuring 1.6 cm x 0.6 cm. The stage 2 PU increased in size through 7/21/14 to a 10 cm x 4 cm stage 2 pressure ulcer. On 7/25/14 Wound Tracking Forms' documentation indicated R7 had the following pressure ulcers:

(1) a. Wound #1: 0.1 cm x 0.1 cm open area stage 2 PU left buttocks.
(2) b. Wound #2: 1.0 cm x 0.8 cm x 0.3 cm deep stage 3 PU (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) on right buttocks.
(3) c. Wound #3: 3.0 cm x 2.0 cm stage 3 PU on right buttocks.
(4) d. Wound #4: 0.5 cm x 0.5 cm x 0.1 cm deep

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{F 314}	Continued From page 13 stage 2 PU on right buttocks (5) e. Wound #5: 3.0 cm x 2.0 cm x 1.0 cm deep stage 2 PU right buttocks. (6) f. Wound #6: 1.0 cm x 0.2 cm x 0.1 cm deep stage 2 PU right buttocks. (7) g. Wound #7: 2.0 cm x 1.8 cm x 0.1 cm deep stage 2 PU right buttocks The following notes were documented in progress notes: (1) 7/21/14- 4:39 p.m. Skin/Wound Note -"Resident continues with skin breakdown on (R) inner buttock area. Measured at 10 x 4 cm with bloody drainage noted. Mepilex applied. Documented. Will continue to monitor"; (2) 7/25/14- 2:26 p.m. Skin/Wound Note- "Skin assessment with new open areas on (R) buttock and small open area on left buttock. Mepilex dressing applied to R buttock and left buttock open to air"; (3) 7/27/14- 5:03 p.m. Skin/Wound Note -Late entry 7:30 a.m.. "Called into room related to resident's right buttock, noted pressure areas with increased depth and red in color. Aquacel and Mepilex dressings applied. Mepilex only applied to left buttock stage 2 pressure area." 10:00 a.m.- "3 cm red drainage noted on right buttock dressing, dressing changed and larger Mepilex along with new Aquacel applied. Will fax physician for order to have wound care Physical Therapy (PT) to see. Family notified of open areas and need for resident to lay down on side. " The pressure ulcers noted on the buttocks were eventually healed. Review of R7's medical record revealed a Wound Tracking Form dated 2/7/15, which included documentation that R7 had developed a recurrent stage 2 PU. The form lacked documentation which identified the location of the PU but	{F 314}		

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identified the wound as a 0.8 cm x 2.5 cm open area with red drainage and a pink wound bed. There was no further documentation on any Wound Tracking Forms since 2/7/15 to indicate staff had monitored the progress of the PU, whether it had improved and/or worsened. The medical record lacked any other assessment of the resident's skin integrity and supporting structures to determine how long pressure could be applied to one area without ill effect.

When interviewed on 2/19/15, at 1:24 p.m. NA-A stated R7 was toileted in the a.m. after getting up and after breakfast then after lunch. NA-A further indicated that repositioning was provided for R7 when she was toileted. NA-A stated she was aware that R7 had a PU and should be repositioned every 2 hours.
When NA-B was interviewed on 2/19/15, 2:26 p.m. she stated R7 required the assistance of two staff (extensive assist) and utilized the EZ stand lift to transfer and toilet. NA-B stated R7 was toileted before breakfast, after breakfast, after lunch, and in the p.m. and stated R7 received repositioning when toileted.
During observation of resident cares on 2/20/15 at 5:57 a.m. R7 was observed lying in bed on her back (supine position) with the bed in the low position. At 6:19 a.m. NA-A entered R7's room to assist R7 out of bed, and at 6:21 a.m. NA-C joined to assist with the transfer from bed with the use of an EZ stand mechanical lift. After completion of cares, at 6:24 a.m. NA-A and NA-C positioned R7 on the edge of her bed in seated position and attached the support belt on the lift swing to transfer from the bed into the bathroom. It was noted that R7 had a pressure relieving cushion in the seat of the wheelchair. It was observed that R7 had a 4 x 4 dressing

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applied to the right gluteal fold when assisted from the toilet. When questioned whether the area was painful R7 stated, "It hurts when I sit too long but not right now".

The care plan revised/reviewed on 1/19/15, identified a goal that R7 would remain free of further skin breakdown and identified her at risk for PU development related to medications, ADL needs, bowel incontinence, decreased range of motion, pain and medical diagnosis. However, the care plan had not been updated to include the current gluteal fold PU and failed to identify any new individualized interventions related to the PU.

During interview with the DON and RN-A on 2/20/15, at 8:10 a.m. it was verified the care plan had not been revised nor modified to include the current PU nor had a comprehensive reassessment been conducted related to R7's risk factors other than the Braden assessment dated 10/30/14, which identified R7 with a score of 18, indicating mild risk for PU development. The DON verified there was no assessment of the skin integrity and it's supporting structures to determine how long pressure could be applied to one area without ill effect. The facility was unable to determine whether a 2 hour repositioning schedule was effective to maintain and/or promote skin integrity for R7. However, the DON verified the facility practice had been to reposition residents when they were toileted. The toileting schedule was defined as: before and after breakfast, after lunch and in the p.m. This toileting/repositioning schedule did not allow/provide for a consistent 2 hour schedule, but had the potential for residents to be repositioned between 3-4 hours (as residents toileted immediately after breakfast and then not

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{F 314}	Continued From page 16 again until after the noon lunch). R7 had a history of multiple pressure ulcers located on the coccyx and recently developed another coccyx ulcer on 2/7/15. The facility did not develop an individualized plan of care based on a comprehensive reassessment to identify what interventions should be implemented or modified to help decrease the risk of R7 developing additional pressure ulcers and to promote healing of the ulcer located on the coccyx. A lack of assessment to determine whether a 2 hour repositioning schedule was appropriate for R7 was not conducted and modifications and revisions to the care plan were not developed and monitored to determine effectiveness. This practice resulted in actual harm for R7. R19, who had a history of pressure ulcers, developed a pressure ulcer on the left ankle on 1/20/15. A comprehensive reassessment was not conducted nor were individualized interventions developed to promote healing and prevent further deterioration. In addition, the facility failed to provide wound treatment per physician order and failed to conduct a physical therapy wound evaluation as ordered by the physician on 1/20/15. R19 was admitted on 8/14/13, and had current diagnoses listed on the care plan that included: history of trans-ischemic accident, hypertension, history of malignant neoplasm and dementia. The quarterly MDS assessment dated 12/31/14, identified R19 with severe cognition impairment and required extensive assistance of staff with, bed mobility, dressing, transfers and mobility.	{F 314}		

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{F 314}	Continued From page 17 During review of R19's medical record it was noted a Wound Tracking Form had been initiated on 1/20/15, which identified R19 as having an unstageable pressure ulcer located on the left ankle measuring 0.5 cm x 0.3 cm. The most recent documentation on the Wound Tracking Form was dated 2/14/15, which identified an unstageable pressure to the left ankle. No wound measurements were documented on 2/14/15. A Braden Scale assessment had been conducted on 10/28/14 and identified R19 as having a score of 18, indicating mild risk for pressure ulcer development. The following nursing progress notes were documented: (1) 1/29/15- 3:18 p.m. "Resident noted with spa today, per NAR (nursing assistant) on the 6-2 shift. Resident noted with open area on a heel [which heel, is not specified]. Resident noted with no other skin issues reported today from info sheet received." (2) 2/12/15- 3:06 p.m. "Resident noted with spa today, per NAR, on the 6-2 shift. Resident noted with no skin issues reported. Fingernails were clipped only." (3) 2/19/15- 1:10 p.m. "Resident had spa today. Tolerated well. Vitals and weight obtained. Ears washed. Peri area washed. Does not shave. Fingernails and toenails checked not clipped. Open area remains on left ankle, dressed by nurse." (4) 2/19/15- 11:15 a.m. "Round mepilex with center cut out applied to left outer ankle to protect it and wrapped with kerlix. Left outer ankle has been reddened with open area." During observation of morning cares on 2/20/15 at 7:30 a.m., NA-C and NA-R assisted R19 out of bed with the use of an EZ stand mechanical lift.	{F 314}		

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{F 314}	Continued From page 18 R19 was noted to have a boot on her left ankle when staff uncovered her foot. NA-C stated R19 was dependent on staff to turn, reposition and transfer from the bed.. During observation of R19's left ankle wound on 2/20/15 at 8:05 a.m. with the DON and RN-A present, a dime sized open area on the outer aspect of the left ankle was noted. The wound was dressed with a Mepilex dressing with center cut out and the dressing was covered with gauze. The wound was reddened at the periphery and had drainage noted. The DON and RN-A stated they were not sure whether the Mepilex dressing with the center cut out was making the wound improve or worsen. They stated it looked worse and appeared red in color. R19's care plan identified her as at risk for pressure ulcers related to needing extensive assistance with bed mobility and having occasional urinary incontinence. Other risk factors for further skin breakdown included: needing assistance with her ADLs including bed mobility, diagnosis-cognitive impairment, needing assistance with her ADLs, decreased communication and history of a PU. The care plan failed to identify that R19 currently had a PU located on the left ankle nor were there any interventions identified related to this condition. During interview with the DON and RN-A on 2/20/15, at 8:15 a.m. neither staff could locate a physician order for the use of the Mepilex dressing for the wound. The DON verified there had been no reassessment of R19 for pressure ulcer risk after development of the pressure ulcer (1/20/15) and verified the care plan had not been revised to reflect interventions to promote healing and prevent further skin breakdown of the identified PU. The DON verified there was no	{F 314}		

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{F 314}	Continued From page 19 assessment of the skin integrity and it's supporting structures to determine how long pressure could be placed on one area without ill effect. Further, the DON stated R19 had a physician order to be seen by physical therapy for a wound treatment evaluation on 1/20/15 but the evaluation had not yet been completed (a full month later 2/20/15). R19 was identified with a history of pressure ulcers and developed a new PU on the left ankle region. The facility failed to reassess R19's risk factors after development of the PU and failed to identify individualized interventions necessary for staff to implement to prevent further PU breakdown. The treatment utilized had not been ordered by the physician and a wound evaluation by physical therapy ordered by the physician (1/20/15) had not yet been conducted for R19 so that timely treatment could be developed and implemented.	{F 314}		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		3/13/15

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 _____	R 02/20/2015

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

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F 520	Continued From page 20 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and implement appropriate plans of actions to correct the identified quality deficiencies related to pressure ulcer assessment and care plan revision/modification to promote proper healing and prevention of pressure ulcers. This practice had the potential to affect all residents in the facility at risk for pressure ulcer development and skin breakdown. Findings include: The facility conducted a quality assessment and assurance (QAA) committee meeting on 1/27/15. During review of the QAA meeting minutes documentation it was noted that a review of the survey results (exited on 12/19/14) was not communicated nor was any corrective action discussed by the members. In the note section listed for pressure ulcers on QAA communication note sheet there were two entries- (1) entry identified the facility talked about supplies and (2) entry simply identified "heel". The director of nursing (DON) was interviewed on 2/20/15, at	F 520	F520 A Lutz Wing QA meeting was held on March 11, 2015 to discuss survey findings from the surveys exited on December 19, 2014, and February 20, 2015 and corrective actions in process to correct issues identified. On 3/13/2015, the nursing staff was educated on the plans of action to correct the deficiencies identified in the December 19, 2014 and February 20, 2015. The Lutz Wing Director of Nursing and Lutz Wing Administrator will ensure Lutz Wing QA meetings will continue to be scheduled at minimum on a quarterly basis and as needed. The next scheduled QA meeting is April 15, 2015. The April 15, 2015 meeting and any QA meeting thereafter will address survey results and corrective action plans, if applicable, for surveys exited during the period between QA committee meetings. The DON and Administrator will convene	

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F 520	Continued From page 21 8:35 a.m. about the QAA meeting and stated the survey results were discussed. However, documentation in the minutes lacked any discussion related to the identified deficient quality of care practices identified on the recertification survey dated 12/19/14. The DON further stated she did not have enough time to conduct the skin care audits on the care plans as stated in the approved plan of correction. The DON could not provide any evidence that staff communication related to the findings and deficient quality practices had occurred since the recert survey dated 12/19/14. Refer to tags: F314 Based on observation, interview and document review the facility failed to conduct a comprehensive reassessment when pressure ulcers were identified, failed to ensure staff monitored and provided care that promoted healing and failed to develop measures to prevent further deterioration and reduce the risk of new pressure ulcers for 3 of 3 residents (R29, R7 and R19) reviewed who had facility acquired pressure ulcers and who all had a history of pressure ulcers. This caused actual harm for R29 and R7. (1) R29, who had a history of pressure ulcers, developed an unstageable ankle pressure ulcer on 1/6/15 which increased in size from 0.5 cm to 1.0 cm by 2/14/15. R29 did not receive the treatment as ordered by the physician, nor was the fleece boot utilized consistently to the foot nor was a comprehensive reassessment conducted and subsequent interventions developed to promote healing and prevent further deterioration. This practice resulted in actual harm to R29.	F 520	the QA committee more frequently than quarterly as needed to respond to survey results or other QA issues. The QA committee meeting agenda template was revised to include survey results as a permanent meeting agenda item. The Administrator will ensure that each QA committee meeting agenda includes the survey results and corrective action, if applicable, as a discussion topic. Completion Date: 3/13/15	

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F 520	Continued From page 22 (2) R7 had a history of multiple pressure ulcers (Stage 2 and Stage 3) located on the coccyx and developed a recurrent coccyx ulcer on 2/7/15 without a comprehensive reassessment and individualized interventions to monitor the condition of the ulcer and promote healing and prevent further deterioration. This practice resulted in actual harm for R7. (3) R19, with a history of pressure ulcers, developed a pressure ulcer on the left ankle on 1/20/15. A comprehensive reassessment was not conducted nor were individualized interventions developed to promote healing and prevent further deterioration. In addition, the facility failed to provide wound treatment per physician order and failed to conduct a physical therapy wound evaluation per physician order on 1/20/15. F280 Based on observation, interview and document review the facility failed to revise and update the care plan for 3 of 3 residents (R29, R7 and R19) reviewed who had facility acquired pressure ulcers.	F 520		

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on March 19, 2015

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

Re: Project # S5274024

Dear Ms. Campbell:

On February 20, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 20, 2015 with orders received by you on March 3, 2015.

State licensing orders issued pursuant to the last survey completed on December 19, 2015 and found corrected at the time of this February 20, 2015 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on December 19, 2015, found not corrected at the time of this February 20, 2015 revisit and subject to penalty assessment are as follows:

20900 -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers 350.00

The details of the violations noted at the time of this revisit completed on February 20, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below:

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

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on February 20, 2015 additional violations were cited as follows:

20255 -- MN Rule 4658.0070 -- Quality Assessment And Assurance Committee
20570 -- MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision

They are delineated on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, when all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194.

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.

Sincerely,

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

Enclosure

cc: Licensing and Certification File
Kathy Serie, Mankato District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

AH Form Approved
3/5/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00359	A. Building B. Wing	2/20/2015

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

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. LSC	01/28/2015	ID Prefix 21390 Reg. # MN Rule 4658.0800 Subp. LSC	01/28/2015	ID Prefix 21435 Reg. # MN Rule 4658.0900 Subp. LSC	01/28/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	03/05/2015	28591	02/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
12/19/2014	

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	00359	A. BUILDING: _____ B. WING _____	R 02/20/2015

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 2/19/15 and 2/20/15. During this onsite visit it was determined that the following corrections order MN Rule 4658.0525 Subp. 3. A. B. was NOT corrected. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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{2 000}	Continued From page 1 possible penalty assessment/s. In addition, two new orders were issued at MN Rule 4658.0405 Subp. 4. and MN rule 4658.0070 at the time of onsite revisit - see 2567 for the new order.	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and	2 255		3/13/15

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2 255	Continued From page 2 assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and implement appropriate plans of actions to correct the identified quality deficiencies related to pressure ulcer assessment and care plan revision/modification to promote proper healing and prevention of pressure ulcers. This practice had the potential to affect all residents in the facility at risk for pressure ulcer development and skin breakdown. Findings include: The facility conducted a quality assessment and assurance (QAA) committee meeting on 1/27/15. During review of the QAA meeting minutes documentation it was noted that a review of the survey results (exited on 12/19/14) was not communicated nor was any corrective action discussed by the members. In the note section listed for pressure ulcers on QAA communication note sheet there were two entries- (1) entry identified the facility talked about supplies and (2) entry simply identified "heel". The director of nursing (DON) was interviewed on 2/20/15, at 8:35 a.m. about the QAA meeting and stated the survey results were discussed. However, documentation in the minutes lacked any discussion related to the identified deficient	2 255	corrected	

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2 255	Continued From page 3 quality of care practices identified on the recertification survey dated 12/19/14. The DON further stated she did not have enough time to conduct the skin care audits on the care plans as stated in the approved plan of correction. The DON could not provide any evidence that staff communication related to the findings and deficient quality practices had occurred since the recert survey dated 12/19/14. Refer to 0900-Based on observation, interview and document review the facility failed to conduct a comprehensive reassessment when pressure ulcers were identified, failed to ensure staff monitored and provided care that promoted healing and failed to develop measures to prevent further deterioration and reduce the risk of new pressure ulcers for 3 of 3 residents (R29, R7 and R19) reviewed who had facility acquired pressure ulcers and who all had a history of pressure ulcers. This caused actual harm for R29, R7 and R19. (1) R29, who had a history of pressure ulcers, developed an unstageable ankle pressure ulcer on 1/6/15 which increased in size from 0.5 cm to 1.0 cm by 2/14/15. R29 did not receive the treatment as ordered by the physician, nor was the fleece boot utilized consistently to the foot nor was a comprehensive reassessment conducted and subsequent interventions developed to promote healing and prevent further deterioration. This practice resulted in actual harm to R29. (2) R7 had a history of multiple pressure ulcers (Stage 2 and Stage 3) located on the coccyx and developed a recurrent coccyx ulcer on 2/7/15 without a comprehensive reassessment and individualized interventions to monitor the condition of the ulcer and promote healing and	2 255		

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2 255	Continued From page 4 prevent further deterioration. This practice resulted in actual harm for R7. (3) R19, with a history of pressure ulcers, developed a pressure ulcer on the left ankle on 1/20/15. A comprehensive reassessment was not conducted nor were individualized interventions developed to promote healing and prevent further deterioration. In addition, the facility failed to provide wound treatment per physician order and failed to conduct a physical therapy wound evaluation per physician order on 1/20/15. Refer to 0570-Based on observation, interview and document review the facility failed to revise and update the care plan for 3 of 3 residents (R29, R7 and R19) reviewed who had facility acquired pressure ulcers. SUGGESTED METHOD OF CORRECTION: The director of nursing and administrator could communicate the findings from the survey to the QAA committee for review and develop a plan to ensure the residents at risk for skin breakdown are identified, assessments conducted with subsequent individualized interventions developed on the plan of care. An audit could be developed and weekly audits conducted to ensure the plan is implemented. The data could be reported to the QAA committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision	2 570		3/13/15

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2 570	Continued From page 5 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised 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, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise and update the care plan for 3 of 3 residents (R29, R7 and R19) reviewed who had facility acquired pressure ulcers. Findings include: R29 was admitted on 12/11/12 and current diagnoses listed on the care plan included: atrial fibrillation, cerebrovascular disease, peripheral vascular disease (PVD) and hypertension. On 2/19/15, at 12:05 p.m. R29 was identified by the director of nursing (DON) to have a stage 2 pressure ulcer (PU) on the outside right ankle region which was acquired (1/6/15)while at the facility. During observation of morning cares on 2/20/15, at 6:46 a.m. NA-A removed a long body pillow from behind R29's back, which had maintained her in a right side lying position. During the observation staff removed R29's blanket from her	2 570	corrected	

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2 570	Continued From page 6 foot region and the right foot and ankle area was noted covered with gauze. There was no evidence of a foot boot when the covers were removed. When staff were questioned about the location of the boot, NA-A pointed on top of R29's clothing cabinet and the boot was on top of the cabinet. NA-A stated R29 frequently kicked the boot off. It was also noted that R29's right ankle was resting on the mattress of the bed when in the right side lying position. During review of R29's medical record it was noted on a Wound Tracking Form that R29 was identified with a unstageable pressure ulcer located on the right outer ankle which measured 0.5 x 0.5 centimeters (cm) on 1/6/15. The Wound Tracking Form documentation identified the ankle wound continued to increase in size (1.0 cm) circumference and was identified as a stage 2 PU when last documented on 2/14/15. The care plan dated 1/20/15, identified that R29 was at risk for PU related to needing staff assistance with bed mobility, weight loss and at risk for pressure ulcers. Other risk factors included: needs assistance with all activities of daily living (ADLs), has cognitive impairment, decreased communication, intermittent pain, history of pressure ulcers, diagnosis and occasional urinary incontinence. Interventions identified on the care plan included: (1) encourage adequate nutritional intake; (2) offer 240 ml Ensure (supplement) twice daily; (3) monitor and treat early S&S (signs and symptoms) of skin irritation and or breakdown; (4) the use of air mattress on her bed; and (5) a use of a wheelchair cushion with soft backed wheelchair. The care plan was last revised/reviewed on 8/5/14 for PU risk and it failed to identify that R29 had an active pressure	2 570		

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2 570	Continued From page 7	2 570		

ulcer. Interventions were not evident on the care plan related to an individualized repositioning schedule, the identification of the type of treatment utilized nor that utilized a boot on her foot.

During an interview on 2/19/15, at 1:02 p.m. the DON verified there had not been a revision nor update documented on the care plan to identify that any additional interventions that had been implemented since the identification of the pressure ulcer/wound which had increased in size.

R7 admitted on 5/20/13 and had active diagnoses listed on the care plan which included: neurogenic bladder, history of foot ulcer, stage 2, multiple sclerosis (MS), history of low back pressure ulcer, history of buttocks pressure ulcer, malaise and fatigue.

Review of R7's medical record revealed a Wound Tracking Form dated 2/7/15 identified R7 with a stage 2 PU. The form lacked documentation which identified the location of the PU but identified the wound size as a 0.8 cm x 2.5 cm open area with red drainage and a pink wound bed. There was no further documentation on any of the Wound Tracking Forms since 2/7/14 to monitor the progress of the PU, whether it had improved and/or worsened.

During observation of resident cares on 2/20/15 at 5:57 a.m. R7 was observed lying on her bed on her back (supine position) with the bed in the low position. At 6:19 a.m. NA-A entered room to assist R7 out of bed and at 6:21 a.m. NA-C joined to assist with the transfer from bed with the use of an EZ stand mechanical lift. After completion of cares, at 6:24 a.m. NA-A and NA-C positioned

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2 570	Continued From page 8 R7 on the edge of her bed in seated position and attached the support belt from the lift swing to transfer R7 from the bed into the bathroom. When assisted from the toilet, it was observed that R7 had a 4 x 4 dressing applied to the right gluteal fold. When questioned whether the area was painful R7 stated, "It hurts when I sit too long but not right now". R7's last revised care plan dated 1/19/15 failed to identify the gluteal fold PU (2/8/15) and failed to revise and modify any interventions related to the PU. This care plan identified that R7 would remain free of further skin breakdown and identified her at risk for PU development related to medications, ADL needs, bowel incontinence, decreased range of motion, pain and medical diagnosis. However, the care plan had not been revised and modified to reflect the current status of the resident. During interview with the DON and RN-A on 2/20/15, at 8:10 a.m. it was verified the care plan had not been revised and/or modified. R19 was admitted on 8/14/13 and had current diagnoses listed on the care plan which included: history of transischemic accident, hypertension, history of malignant neoplasm and dementia. During review of R19's medical record it was noted there was a Wound Tracking Form initiated 1/20/15 which identified an unstageable PU measured 0.5 cm x 0.3 cm and located on the left ankle. The Wound Tracking Form was last documented on 2/14/15 which identified an unstageable PU on the left ankle. During observation of a.m. cares on 2/20/15 at 7:30 a.m. NA-C and NA-R assisted R19 out of	2 570		

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2 570	Continued From page 9 bed with the use of a EZ stand mechanical lift. R19 was noted to have a boot on her left ankle when staff uncovered her foot. NA-C stated R19 was dependent of staff to turn and reposition and transfer out of bed. R19's care plan identified her at risk for PU related to needing extensive assistance with bed mobility and occasional urinary incontinence. Other risk factors for further skin breakdown included-needing assistance with her ADLs including bed mobility, diagnosis, cognitive impairment, needing assistance with her ADLs, decreased communication and , history of a pressure ulcer. The care plan failed to identify that R19 had a current pressure ulcer located on the left ankle (1/20/15) nor were there any revisions and modifications identified related to the current PU. During interview with the DON and RN-A on 2/20/15, at 8:15 a.m. neither staff could locate a physician order for the use of the Mepilex dressing for the wound. The DON verified verified the care plan had not been revised to reflect interventions to promote healing and prevent further skin breakdown of the identified PU nor had the current treatment plan been added to the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop a system to ensure the care plan is updated and revised as resident condition changes. The DON could educate staff on the importance of maintaining a current care plan. An audit could be completed to ensure care plans are up to date and the findings could be reported to the quality assurance committee.	2 570		

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2 570	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings. The original licensing order issued on 12/19/15 will remain in effect. Penalty assessment issued." Based on observation, interview and document review, the facility failed to conduct a comprehensive reassessment when pressure ulcers were identified, failed to ensure staff monitored and provided care that promoted healing, and failed to develop measures to prevent further deterioration and reduce the risk of new pressure ulcers for 3 of 3 residents (R29,	{2 900}	corrected	3/16/15

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{2 900}	Continued From page 11 R7, R19) reviewed who had facility acquired pressure ulcers, and who all had a history of pressure ulcers. These deficient practices caused actual harm for R29 and R7. Findings include: R29, who had a history of pressure ulcers, developed an unstageable ankle pressure ulcer on 1/6/15 which increased in size from 0.5 cm to 1.0 cm by 2/14/15. R29 did not receive the treatment as ordered by the physician, nor was the fleece boot utilized consistently to the foot nor was a comprehensive reassessment conducted and subsequent interventions developed to promote healing and prevent further deterioration. This practice resulted in actual harm to R29. R29 was admitted to the facility on 12/11/12 and had current diagnoses listed on the care plan which included: atrial fibrillation, cerebrovascular disease, peripheral vascular disease and hypertension. R29's most recent quarterly Minimum Data Set (MDS) assessment dated 1/7/15, identified R29 required extensive assistance of one to two staff with bed mobility, transfer, mobility, dressing and toileting. The Brief Interview for Mental Status (BIMS) indicated R29 had a score of 12, indicating mild cognitive impairment. The assessment further identified that R29 had an unstageable pressure ulcer (PU) on her right outer ankle. During record review it was identified that R29 had a history of pressure ulcers which included a stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) located on her middle coccyx region which healed on 5/1/14.	{2 900}		

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{2 900}	Continued From page 12 On 2/19/15, at 12:05 p.m. R29 was identified by the director of nursing (DON) to have a stage 2 PU on the outside right ankle region which was recently acquired (1/6/15) while at the facility. When nursing progress notes were reviewed documentation on 12/4/14, identified that R29 complained of pain on the right outer ankle and staff discovered a 0.5 cm scabbed area with peripheral redness and a Polymer dressing was subsequently applied to the area. There was no further documentation related to the red scabbed area in the medical record until 1/6/15, when the unstageable PU located on the right outer ankle was identified. During further medical record review it was noted on a Wound Tracking Form that R29 was identified with a unstageable PU located on the right outer ankle which measured 0.5 x 0.5 centimeters (cm) on 1/6/15. Documentation on the Wound Tracking Form identified the ankle PU continued to increase in circumference size (1.0 cm) and was documented as a stage 2 PU on 2/14/15. A nursing progress note dated 2/14/15, timed 12:56 p.m. identified that R29 had an open area on her right ankle that appeared red and swollen and measured as a 1.0 cm open area on ankle. The note documented that staff reapplied a Mepilex dressing, doubled, with a cut open area and wrapped with kerlix and no further documentation since 2/14/15 entry. A Braden Scale assessment (tool used to determine risk for pressure ulcer development) was conducted on 1/7/15, which identified that R29 had a score of 17, indicating only a mild risk of developing pressure ulcers. However, the medical record lacked an assessment of the skin integrity and it's supporting structures to determine how long pressure can be on one area	{2 900}		

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{2 900}	Continued From page 13	{2 900}		

without ill effect.
During an interview on 02/19/15, at 1:02 p.m. the DON stated she did not have a comprehensive reassessment related to the PU/skin integrity for R29 and verified there had not been any revision documented on the care plan to identify that any additional interventions had been implemented since the identification of the pressure ulcer/wound which had increased in size.

When interviewed on 2/19/15, at 1:24 p.m. nursing assistant (NA)-A stated R29 was toileted in the a.m. after getting up and after breakfast and then after lunch. NA-A further stated R29 repositioned herself so they did not reposition her unless she would request the assistance even though the MDS identified R29 required staff assistance with bed mobility.

When NA-B was questioned on 2/19/15, at 2:26 p.m. NA-B stated R29 required the assistance of one to two staff (extensive assist) or utilized the EZ stand lift at times for transfer and toileting needs. NA-B further stated R29 was routinely toileted before breakfast, after breakfast, after lunch, then in the p.m. and stated that R29 was repositioned when toileted.

During observation of morning cares on 2/20/15, at 6:46 a.m. NA-A removed a long body pillow from behind R29's back, which had maintained her in a right side lying position. During the observation staff removed R29's blanket from her foot region and the right foot and ankle area was covered with gauze. There was no evidence of a foot boot when the covers were removed. When staff was questioned about the location of the boot, NA-A pointed on top of R29's clothing cabinet and the boot was located on the top of the cabinet. NA-A stated R29 frequently kicked

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{2 900}	Continued From page 14	{2 900}		

the boot off. It was also noted that R29's right ankle was resting on the mattress of the bed when positioned in the right side lying position.

The care plan dated 1/20/15, identified that R29 was at risk for PU related to needing staff assistance with bed mobility, weight loss and at risk for pressure ulcers. Other risk factors included: needs assistance with all activities of daily living (ADLs), has cognitive impairment, decreased communication, intermittent pain, history of pressure ulcers, diagnosis and occasional urinary incontinence. Interventions identified on the care plan included: (1) encourage adequate nutritional intake; (2) offer 240 ml Ensure (supplement) twice daily; (3) monitor and treat early S&S (signs and symptoms) of skin irritation and or breakdown; (4) the use of air mattress on her bed; and (5) a use of a wheelchair cushion with soft backed wheelchair. The care plan failed to identify that R29 had a current PU and no interventions were developed related to an individualized repositioning schedule based on a comprehensive reassessment, the identification of the treatment utilized nor that a boot was applied to the foot at night.

When interviewed on 2/20/15, at 7:30 a.m. registered nurse (RN)-A stated R29 had a physician order for use of a fleece boot at hours of sleep to prevent pressure. RN-A further stated R29 had a physician order dated 1/8/15 for use of Tincture of Benzoin and a thick corn pad applied over the PU located on the right outer ankle area. However, RN-A stated staff utilized a Mepilex foam dressing with the center cut out and applied gauze over the dressing. The dressing was changed as needed and every 3 days. RN-A indicated there was no specific physician order

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{2 900}	Continued From page 15 for this particular treatment. RN-A verified she was unable to locate any comprehensive reassessment after discovery of the PU nor were there any PU interventions evident on the care plan. RN-A stated the charge nurse should have updated the care plan to reflect the condition of R29 and should have assessed the wound so that individualized interventions could be developed and implemented. When interviewed on 2/20/15, at 7:40 a.m. charge nurse/RN-B stated that upon discovery of a PU, it would be measured and the family and doctor notified. RN-B indicated that a Wound Tracking Form would be initiated, the identification of the PU would be documented in the wound book and the DON notified. RN-B stated there had not been a comprehensive reassessment completed related to all the risk factors for R29. The only assessment conducted was the Braden assessment which did not accurately reflect all the risk factors. RN-B stated all residents are placed on a two hour repositioning schedule when a PU is identified to reduce the risk of further development. RN-B verified there had not been a reassessment conducted to confirm the 2 hour schedule was appropriate for R29 nor had a care plan been developed subsequent to the development of the PU located on R29's ankle. Although the medical record identified that R29's PU located on the ankle increased in size from the initial measurement (dated 1/6/15) of 0.5 cm x 0.5 cm unstageable to a 1.0 cm x 1.0 cm PU dated 2/14/15, the facility failed to develop an individualized plan of care based on a comprehensive assessment to identify what interventions should be implemented or modified to help decrease the risk of R29 developing additional pressure ulcers and promote healing.	{2 900}		

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{2 900}	Continued From page 16 There was no indication the pressure ulcer was consistently monitored. Further R29 had an order for the use of a boot on her right foot to protect her ankle and reduce pressure. Because staff had not routinely applied the boot due to R29's frequent removal of the boot, evidence was lacking to indicate interventions had been modified and re-evaluated for alternative approaches. The facility applied a Mepilex foam dressing to the ankle instead of the physician ordered Tincture of Benzoin and a thick corn pad. This practice resulted in actual harm to R29. R7 had a history of multiple pressure ulcers (Stage 2 and Stage 3) located on the coccyx and developed a recurrent coccyx ulcer on 2/7/15 without a comprehensive reassessment and individualized interventions to promote healing and prevent further deterioration. Monitoring of the ulcer was lacking .This practice resulted in actual harm for R7. R7, admitted 5/20/13 had diagnoses listed on the care plan which included: neurogenic bladder, history of foot ulcer, stage 2, multiple sclerosis (MS), history of low back pressure ulcer, history of buttocks pressure ulcer malaise and fatigue. The quarterly MDS assessment dated 12/31/14 identified R7 with a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. Documentation further indicated that R7 required extensive assistance of two staff with bed mobility, transfers from bed and chair and with toileting. Documentation on the assessment also identified that R7 had stage 2 PU over a bony prominence. Documentation in the medical record identified that R7 had a history of multiple pressure ulcers.	{2 900}		

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{2 900}	Continued From page 17 Documentation dated 5/6/15 on a Wound Tracking Form identified R7 with a stage 2 PU on the right gluteal fold region and it measured 1.6 cm x 0.6 cm stage 2 and increased in size through 7/21/14 to a 10 cm x 4 cm stage 2 pressure ulcer. On 7/25/14 R7 was identified with the following pressure ulcers as documented on the Wound Tracking Forms: (1) a. Wound 1- 0.1 cm x 0.1 cm open area stage 2 PU left buttocks. (2) b. Wound 2- 1.0 cm x 0.8 cm x 0.3 cm deep stage 3 PU (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) on right buttocks. (3) c. Wound 3- 3.0 cm x 2.0 cm stage 3 PU on right buttocks. (4) d. Wound 4- 0.5 cm x 0.5 cm x 0.1 cm deep stage 2 PU on right buttocks (5) e. Wound 5- 3.0 cm x 2.0 cm x 1.0 cm deep stage 2 PU right buttocks. (6) f. Wound 6- 1.0 cm x 0.2 cm x 0.1 cm deep stage 2 PU right buttocks. (7) g. Wound 7- 2.0 cm x 1.8 cm x 0.1 cm deep stage 2 PU right buttocks The following notes were documented in progress notes: (1) 7/21/14- 4:39 p.m. Skin/Wound Note -Resident continues with skin breakdown on (R) inner buttock area. Measured at 10 x 4 cm with bloody drainage noted. Mepilex applied. Documented. Will continue to monitor; (2) 7/25/14- 2:26 p.m. Skin/Wound Note Skin assessment with new open areas on (R) buttock and small open area on left buttock. Mepilex dressing applied to R buttock and left buttock open to air; (3) 7/27/14- 5:03 p.m. Skin/Wound Note -Late entry 7:30 a.m.. Called into room related to residents right buttock noted pressure	{2 900}		

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{2 900}	Continued From page 18	{2 900}		

areas with increased depth and red in color. Aquacel and Mepilex dressings applied. Mepilex only applied to left buttock stage 2 pressure area. 10:00 a.m.- 3 cm red drainage noted on right buttock dressing, dressing changed and larger Mepilex along with new Aquacel applied. Will fax physician for order to have wound care Physical Therapy (PT) to see. Family notified of open areas and need for resident to lay down on side. The pressure ulcers noted on the buttocks were eventually healed.

Review of R7's medical record revealed the Wound Tracking Form dated 2/7/15, had documentation that R7 had developed a recurrent stage 2 PU. The form lacked documentation which identified the location of the PU but identified the wound as a 0.8 cm x 2.5 cm open area with red drainage and a pink wound bed. There was no further documentation on any Wound Tracking Forms since 2/7/15 to indicate staff had monitored the progress of the PU, whether it had improved and/or worsened.

During observation of resident cares on 2/20/15 at 5:57 a.m. R7 was observed lying on her bed on her back (supine position) with the bed in the low position. At 6:19 a.m. NA-A entered room to assist R7 out of bed and at 6:21 a.m. NA-C joined to assist with the transfer from bed with the use of an EZ stand mechanical lift. After completion of cares, at 6:24 a.m. NA-A and NA-C positioned R7 on the edge of her bed in seated position and attached the support belt on the lift swing to transfer from the bed into the bathroom. It was noted that R7 had a pressure relieving cushion in the seat of the wheelchair. It was observed that R7 had a 4 x 4 dressing applied to the right gluteal fold when assisted from the toilet. When questioned whether the area was painful R7

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{2 900}	Continued From page 19 stated, "It hurts when I sit too long but not right now". When interviewed on 2/19/15, at 1:24 p.m. NA-A stated R7 was toileted in the a.m. after getting up and after breakfast then after lunch. NA-A further indicated that repositioning was provided for R7 when she was toileted. NA-A stated she was aware that R7 had a PU and should be repositioned every 2 hours. When NA-B was interviewed on 2/19/15, 2:26 p.m. she stated R7 required the assistance of two staff (extensive assist) and utilized the EZ stand lift to transfer and toilet. NA-B stated R7 was toileted before breakfast, after breakfast, after lunch, then in the p.m. and further stated R7 was repositioned when toileted. The care plan revised/reviewed on 1/19/15 identified that R7 would remain free of further skin breakdown and identified her at risk for PU development related to medications, ADL needs, bowel incontinence, decreased range of motion, pain and medical diagnosis. However, the care plan had not been updated to include the current gluteal fold PU and failed to identify any new individualized interventions related to the PU. During interview with the DON and RN-A on 2/20/15, at 8:10 a.m. it was verified the care plan had not been revised nor modified to include the current PU nor had a comprehensive reassessment been conducted related to R7's risk factors other than the Braden assessment dated 10/30/14, which identified R7 with a score of 18, indicating mild risk for PU development. The DON verified there was no assessment of the skin integrity and it's supporting structures to determine how long pressure can on one area without ill effect. The facility was unable to determine whether a 2 hour repositioning	{2 900}		

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{2 900}	Continued From page 20 schedule was effective to maintain and/or promote skin integrity for R7. Facility practice had been to reposition residents when they were toileted. The toileting schedule was defined as: before and after breakfast, after lunch and then p.m. This toileting/repositioning schedule had not allowed/provided for a 2 hour schedule but had residents repositioned potentially between 3-4 hours (as residents toileted immediately after breakfast and then not again until after the noon lunch). R7 had a history of multiple pressure ulcers located on the coccyx and recently developed another coccyx ulcer on 2/7/15. The facility did not develop an individualized plan of care based on a comprehensive reassessment to identify what interventions should be implemented or modified to help decrease the risk of R7 developing additional pressure ulcers and to promote healing of the ulcer located on the coccyx. A lack of assessment to determine whether a 2 hour repositioning schedule was appropriate for R7 was not conducted and modifications and revisions to the care plan were not developed and monitored to determine effectiveness. This practice resulted in actual harm for R7. R19, who had a history of pressure ulcers, developed a pressure ulcer on the left ankle on 1/20/15. A comprehensive reassessment was not conducted nor were individualized interventions developed to promote healing and prevent further deterioration. In addition, the facility failed to provide wound treatment per physician order and failed to conduct a physical therapy wound evaluation as ordered by the physician on 1/20/15.	{2 900}		

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{2 900}	Continued From page 21 R19 was admitted on 8/14/13, and had current diagnoses listed on the care plan that included: history of trans-ischemic accident, hypertension, history of malignant neoplasm and dementia. The quarterly MDS assessment dated 12/31/14, identified R19 with severe cognition impairment and required extensive assistance of staff with, bed mobility, dressing, transfers and mobility. During review of R19's medical record it was noted there was a Wound Tracking Form initiated on 1/20/15, which identified R19 with an unstageable, 0.5 cm x 0.3 cm pressure ulcer located on the left ankle. The most recent documentation on this Wound Tracking Form was dated 2/14/15, which identified an unstageable pressure to the left ankle. No wound measurements were documented on 2/14/15. The medical record lacked an assessment of the skin integrity and it's supporting structures to determine how long pressure can be on one area without ill effect. A Braden Scale assessment was conducted on 10/28/14 and identified R19 with a score of 18, indicating a mild risk for pressure ulcer development. The following nursing progress notes were documented: (1) 1/29/15- 3:18 p.m. Resident noted with spa today, per NAR on the 6-2 shift. Resident noted with open area on a heel [which heel, is not specified]. Resident noted with no other skin issues reported today from info sheet received. (2) 2/12/15- 3:06 p.m. Resident noted with spa today, per NAR, on the 6-2 shift. Resident noted with no skin issues reported. Fingernails were clipped only. (3) 2/19/15- 1:10 p.m. Resident had spa today. Tolerated well. Vitals and weight obtained. Ears washed. Peri area washed. Does not shave.	{2 900}		

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{2 900}	Continued From page 22 Fingernails and toenails checked not clipped. Open area remains on left ankle, dressed by nurse. (4) 2/19/15- 11:15 a.m. Round mepilex with center cut out applied to left outer ankle to protect it and wrapped with kerlix. Left outer ankle has been reddened with open area. During observation of morning cares on 2/20/15 at 7:30 a.m. NA-C and NA-R assisted R19 out of bed with the use of a EZ stand mechanical lift. R19 was noted to have a boot on her left ankle when staff uncovered her foot. NA-C stated R19 was dependent of staff to turn and reposition and transfer from the bed.. During observation of R19's left ankle wound on 2/20/15 at 8:05 a.m. with the DON and RN-A present, a dime sized open area on the outer aspect of the left ankle was noted. The wound was dressed with a Mepilex dressing with center cut out and the dressing was covered with gauze. The wound was reddened at the periphery and had drainage noted. The DON and RN-A stated they were not sure whether the Mepilex dressing with the center cut out was making the wound improve or worsen. They stated it looked worse and appeared red in color. R19's care plan identified her at risk for pressure ulcers related to needing extensive assistance with bed mobility and occasional urinary incontinence. Other risk factors for further skin breakdown included: needing assistance with her ADLs including bed mobility, diagnosis-cognitive impairment, needing assistance with her ADLs, decreased communication and history of a PU. The care plan failed to identify that R19 currently had a PU located on the left ankle nor were there any interventions identified related to this condition. During interview with the DON and RN-A on	{2 900}		

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{2 900}	Continued From page 23 2/20/15, at 8:15 a.m. neither staff could locate a physician order for the use of the Mepilex dressing for the wound. The DON verified there had been no reassessment of R19 for pressure ulcer risk after development of the pressure ulcer (1/20/15) and verified the care plan had not been revised to reflect interventions to promote healing and prevent further skin breakdown of the identified PU. Further, the DON stated R19 had a physician order to be seen by physical therapy for a wound treatment evaluation on 1/20/15 but the evaluation had not yet been completed (month later 2/20/15). R19 was identified with a history of pressure ulcers and developed a new PU on the left ankle region. The facility failed to reassess R19's risk factors after development of the PU and failed to identify individualized interventions necessary for staff to implement to prevent further PU breakdown. The treatment utilized had not been ordered by the physician and a wound evaluation by physical therapy ordered by the physician (1/20/15) had not yet been conducted for R19 so that timely treatment was developed and implemented.	{2 900}		

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2 570	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings. The original licensing order issued on 12/19/15 will remain in effect. Penalty assessment issued." Based on observation, interview and document review, the facility failed to conduct a comprehensive reassessment when pressure ulcers were identified, failed to ensure staff monitored and provided care that promoted healing, and failed to develop measures to prevent further deterioration and reduce the risk of new pressure ulcers for 3 of 3 residents (R29,	{2 900}	corrected	3/16/15

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{2 900}	Continued From page 11 R7, R19) reviewed who had facility acquired pressure ulcers, and who all had a history of pressure ulcers. These deficient practices caused actual harm for R29 and R7. Findings include: R29, who had a history of pressure ulcers, developed an unstageable ankle pressure ulcer on 1/6/15 which increased in size from 0.5 cm to 1.0 cm by 2/14/15. R29 did not receive the treatment as ordered by the physician, nor was the fleece boot utilized consistently to the foot nor was a comprehensive reassessment conducted and subsequent interventions developed to promote healing and prevent further deterioration. This practice resulted in actual harm to R29. R29 was admitted to the facility on 12/11/12 and had current diagnoses listed on the care plan which included: atrial fibrillation, cerebrovascular disease, peripheral vascular disease and hypertension. R29's most recent quarterly Minimum Data Set (MDS) assessment dated 1/7/15, identified R29 required extensive assistance of one to two staff with bed mobility, transfer, mobility, dressing and toileting. The Brief Interview for Mental Status (BIMS) indicated R29 had a score of 12, indicating mild cognitive impairment. The assessment further identified that R29 had an unstageable pressure ulcer (PU) on her right outer ankle. During record review it was identified that R29 had a history of pressure ulcers which included a stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) located on her middle coccyx region which healed on 5/1/14.	{2 900}		

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{2 900}	Continued From page 12 On 2/19/15, at 12:05 p.m. R29 was identified by the director of nursing (DON) to have a stage 2 PU on the outside right ankle region which was recently acquired (1/6/15) while at the facility. When nursing progress notes were reviewed documentation on 12/4/14, identified that R29 complained of pain on the right outer ankle and staff discovered a 0.5 cm scabbed area with peripheral redness and a Polymer dressing was subsequently applied to the area. There was no further documentation related to the red scabbed area in the medical record until 1/6/15, when the unstageable PU located on the right outer ankle was identified. During further medical record review it was noted on a Wound Tracking Form that R29 was identified with a unstageable PU located on the right outer ankle which measured 0.5 x 0.5 centimeters (cm) on 1/6/15. Documentation on the Wound Tracking Form identified the ankle PU continued to increase in circumference size (1.0 cm) and was documented as a stage 2 PU on 2/14/15. A nursing progress note dated 2/14/15, timed 12:56 p.m. identified that R29 had an open area on her right ankle that appeared red and swollen and measured as a 1.0 cm open area on ankle. The note documented that staff reapplied a Mepilex dressing, doubled, with a cut open area and wrapped with kerlix and no further documentation since 2/14/15 entry. A Braden Scale assessment (tool used to determine risk for pressure ulcer development) was conducted on 1/7/15, which identified that R29 had a score of 17, indicating only a mild risk of developing pressure ulcers. However, the medical record lacked an assessment of the skin integrity and it's supporting structures to determine how long pressure can be on one area	{2 900}		

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{2 900}	Continued From page 13 without ill effect. During an interview on 02/19/15, at 1:02 p.m. the DON stated she did not have a comprehensive reassessment related to the PU/skin integrity for R29 and verified there had not been any revision documented on the care plan to identify that any additional interventions had been implemented since the identification of the pressure ulcer/wound which had increased in size. When interviewed on 2/19/15, at 1:24 p.m. nursing assistant (NA)-A stated R29 was toileted in the a.m. after getting up and after breakfast and then after lunch. NA-A further stated R29 repositioned herself so they did not reposition her unless she would request the assistance even though the MDS identified R29 required staff assistance with bed mobility. When NA-B was questioned on 2/19/15, at 2:26 p.m. NA-B stated R29 required the assistance of one to two staff (extensive assist) or utilized the EZ stand lift at times for transfer and toileting needs. NA-B further stated R29 was routinely toileted before breakfast, after breakfast, after lunch, then in the p.m. and stated that R29 was repositioned when toileted. During observation of morning cares on 2/20/15, at 6:46 a.m. NA-A removed a long body pillow from behind R29's back, which had maintained her in a right side lying position. During the observation staff removed R29's blanket from her foot region and the right foot and ankle area was covered with gauze. There was no evidence of a foot boot when the covers were removed. When staff was questioned about the location of the boot, NA-A pointed on top of R29's clothing cabinet and the boot was located on the top of the cabinet. NA-A stated R29 frequently kicked	{2 900}		

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{2 900}	Continued From page 14	{2 900}		

the boot off. It was also noted that R29's right ankle was resting on the mattress of the bed when positioned in the right side lying position.

The care plan dated 1/20/15, identified that R29 was at risk for PU related to needing staff assistance with bed mobility, weight loss and at risk for pressure ulcers. Other risk factors included: needs assistance with all activities of daily living (ADLs), has cognitive impairment, decreased communication, intermittent pain, history of pressure ulcers, diagnosis and occasional urinary incontinence. Interventions identified on the care plan included: (1) encourage adequate nutritional intake; (2) offer 240 ml Ensure (supplement) twice daily; (3) monitor and treat early S&S (signs and symptoms) of skin irritation and or breakdown; (4) the use of air mattress on her bed; and (5) a use of a wheelchair cushion with soft backed wheelchair. The care plan failed to identify that R29 had a current PU and no interventions were developed related to an individualized repositioning schedule based on a comprehensive reassessment, the identification of the treatment utilized nor that a boot was applied to the foot at night.

When interviewed on 2/20/15, at 7:30 a.m. registered nurse (RN)-A stated R29 had a physician order for use of a fleece boot at hours of sleep to prevent pressure. RN-A further stated R29 had a physician order dated 1/8/15 for use of Tincture of Benzoin and a thick corn pad applied over the PU located on the right outer ankle area. However, RN-A stated staff utilized a Mepilex foam dressing with the center cut out and applied gauze over the dressing. The dressing was changed as needed and every 3 days. RN-A indicated there was no specific physician order

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{2 900}	Continued From page 15 for this particular treatment. RN-A verified she was unable to locate any comprehensive reassessment after discovery of the PU nor were there any PU interventions evident on the care plan. RN-A stated the charge nurse should have updated the care plan to reflect the condition of R29 and should have assessed the wound so that individualized interventions could be developed and implemented. When interviewed on 2/20/15, at 7:40 a.m. charge nurse/RN-B stated that upon discovery of a PU, it would be measured and the family and doctor notified. RN-B indicated that a Wound Tracking Form would be initiated, the identification of the PU would be documented in the wound book and the DON notified. RN-B stated there had not been a comprehensive reassessment completed related to all the risk factors for R29. The only assessment conducted was the Braden assessment which did not accurately reflect all the risk factors. RN-B stated all residents are placed on a two hour repositioning schedule when a PU is identified to reduce the risk of further development. RN-B verified there had not been a reassessment conducted to confirm the 2 hour schedule was appropriate for R29 nor had a care plan been developed subsequent to the development of the PU located on R29's ankle. Although the medical record identified that R29's PU located on the ankle increased in size from the initial measurement (dated 1/6/15) of 0.5 cm x 0.5 cm unstageable to a 1.0 cm x 1.0 cm PU dated 2/14/15, the facility failed to develop an individualized plan of care based on a comprehensive assessment to identify what interventions should be implemented or modified to help decrease the risk of R29 developing additional pressure ulcers and promote healing.	{2 900}		

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{2 900}	Continued From page 16 There was no indication the pressure ulcer was consistently monitored. Further R29 had an order for the use of a boot on her right foot to protect her ankle and reduce pressure. Because staff had not routinely applied the boot due to R29's frequent removal of the boot, evidence was lacking to indicate interventions had been modified and re-evaluated for alternative approaches. The facility applied a Mepilex foam dressing to the ankle instead of the physician ordered Tincture of Benzoin and a thick corn pad. This practice resulted in actual harm to R29. R7 had a history of multiple pressure ulcers (Stage 2 and Stage 3) located on the coccyx and developed a recurrent coccyx ulcer on 2/7/15 without a comprehensive reassessment and individualized interventions to promote healing and prevent further deterioration. Monitoring of the ulcer was lacking .This practice resulted in actual harm for R7. R7, admitted 5/20/13 had diagnoses listed on the care plan which included: neurogenic bladder, history of foot ulcer, stage 2, multiple sclerosis (MS), history of low back pressure ulcer, history of buttocks pressure ulcer malaise and fatigue. The quarterly MDS assessment dated 12/31/14 identified R7 with a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. Documentation further indicated that R7 required extensive assistance of two staff with bed mobility, transfers from bed and chair and with toileting. Documentation on the assessment also identified that R7 had stage 2 PU over a bony prominence. Documentation in the medical record identified that R7 had a history of multiple pressure ulcers.	{2 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	R 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 900}	Continued From page 17 Documentation dated 5/6/15 on a Wound Tracking Form identified R7 with a stage 2 PU on the right gluteal fold region and it measured 1.6 cm x 0.6 cm stage 2 and increased in size through 7/21/14 to a 10 cm x 4 cm stage 2 pressure ulcer. On 7/25/14 R7 was identified with the following pressure ulcers as documented on the Wound Tracking Forms: (1) a. Wound 1- 0.1 cm x 0.1 cm open area stage 2 PU left buttocks. (2) b. Wound 2- 1.0 cm x 0.8 cm x 0.3 cm deep stage 3 PU (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) on right buttocks. (3) c. Wound 3- 3.0 cm x 2.0 cm stage 3 PU on right buttocks. (4) d. Wound 4- 0.5 cm x 0.5 cm x 0.1 cm deep stage 2 PU on right buttocks (5) e. Wound 5- 3.0 cm x 2.0 cm x 1.0 cm deep stage 2 PU right buttocks. (6) f. Wound 6- 1.0 cm x 0.2 cm x 0.1 cm deep stage 2 PU right buttocks. (7) g. Wound 7- 2.0 cm x 1.8 cm x 0.1 cm deep stage 2 PU right buttocks The following notes were documented in progress notes: (1) 7/21/14- 4:39 p.m. Skin/Wound Note -Resident continues with skin breakdown on (R) inner buttock area. Measured at 10 x 4 cm with bloody drainage noted. Mepilex applied. Documented. Will continue to monitor; (2) 7/25/14- 2:26 p.m. Skin/Wound Note Skin assessment with new open areas on (R) buttock and small open area on left buttock. Mepilex dressing applied to R buttock and left buttock open to air; (3) 7/27/14- 5:03 p.m. Skin/Wound Note -Late entry 7:30 a.m.. Called into room related to residents right buttock noted pressure	{2 900}		

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{2 900}	Continued From page 18	{2 900}		

areas with increased depth and red in color. Aquacel and Mepilex dressings applied. Mepilex only applied to left buttock stage 2 pressure area. 10:00 a.m.- 3 cm red drainage noted on right buttock dressing, dressing changed and larger Mepilex along with new Aquacel applied. Will fax physician for order to have wound care Physical Therapy (PT) to see. Family notified of open areas and need for resident to lay down on side. The pressure ulcers noted on the buttocks were eventually healed.

Review of R7's medical record revealed the Wound Tracking Form dated 2/7/15, had documentation that R7 had developed a recurrent stage 2 PU. The form lacked documentation which identified the location of the PU but identified the wound as a 0.8 cm x 2.5 cm open area with red drainage and a pink wound bed. There was no further documentation on any Wound Tracking Forms since 2/7/15 to indicate staff had monitored the progress of the PU, whether it had improved and/or worsened.

During observation of resident cares on 2/20/15 at 5:57 a.m. R7 was observed lying on her bed on her back (supine position) with the bed in the low position. At 6:19 a.m. NA-A entered room to assist R7 out of bed and at 6:21 a.m. NA-C joined to assist with the transfer from bed with the use of an EZ stand mechanical lift. After completion of cares, at 6:24 a.m. NA-A and NA-C positioned R7 on the edge of her bed in seated position and attached the support belt on the lift swing to transfer from the bed into the bathroom. It was noted that R7 had a pressure relieving cushion in the seat of the wheelchair. It was observed that R7 had a 4 x 4 dressing applied to the right gluteal fold when assisted from the toilet. When questioned whether the area was painful R7

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{2 900}	Continued From page 19 stated, "It hurts when I sit too long but not right now". When interviewed on 2/19/15, at 1:24 p.m. NA-A stated R7 was toileted in the a.m. after getting up and after breakfast then after lunch. NA-A further indicated that repositioning was provided for R7 when she was toileted. NA-A stated she was aware that R7 had a PU and should be repositioned every 2 hours. When NA-B was interviewed on 2/19/15, 2:26 p.m. she stated R7 required the assistance of two staff (extensive assist) and utilized the EZ stand lift to transfer and toilet. NA-B stated R7 was toileted before breakfast, after breakfast, after lunch, then in the p.m. and further stated R7 was repositioned when toileted. The care plan revised/reviewed on 1/19/15 identified that R7 would remain free of further skin breakdown and identified her at risk for PU development related to medications, ADL needs, bowel incontinence, decreased range of motion, pain and medical diagnosis. However, the care plan had not been updated to include the current gluteal fold PU and failed to identify any new individualized interventions related to the PU. During interview with the DON and RN-A on 2/20/15, at 8:10 a.m. it was verified the care plan had not been revised nor modified to include the current PU nor had a comprehensive reassessment been conducted related to R7's risk factors other than the Braden assessment dated 10/30/14, which identified R7 with a score of 18, indicating mild risk for PU development. The DON verified there was no assessment of the skin integrity and it's supporting structures to determine how long pressure can on one area without ill effect. The facility was unable to determine whether a 2 hour repositioning	{2 900}		

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{2 900}	Continued From page 20 schedule was effective to maintain and/or promote skin integrity for R7. Facility practice had been to reposition residents when they were toileted. The toileting schedule was defined as: before and after breakfast, after lunch and then p.m. This toileting/repositioning schedule had not allowed/provided for a 2 hour schedule but had residents repositioned potentially between 3-4 hours (as residents toileted immediately after breakfast and then not again until after the noon lunch). R7 had a history of multiple pressure ulcers located on the coccyx and recently developed another coccyx ulcer on 2/7/15. The facility did not develop an individualized plan of care based on a comprehensive reassessment to identify what interventions should be implemented or modified to help decrease the risk of R7 developing additional pressure ulcers and to promote healing of the ulcer located on the coccyx. A lack of assessment to determine whether a 2 hour repositioning schedule was appropriate for R7 was not conducted and modifications and revisions to the care plan were not developed and monitored to determine effectiveness. This practice resulted in actual harm for R7. R19, who had a history of pressure ulcers, developed a pressure ulcer on the left ankle on 1/20/15. A comprehensive reassessment was not conducted nor were individualized interventions developed to promote healing and prevent further deterioration. In addition, the facility failed to provide wound treatment per physician order and failed to conduct a physical therapy wound evaluation as ordered by the physician on 1/20/15.	{2 900}		

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{2 900}	Continued From page 21 R19 was admitted on 8/14/13, and had current diagnoses listed on the care plan that included: history of trans-ischemic accident, hypertension, history of malignant neoplasm and dementia. The quarterly MDS assessment dated 12/31/14, identified R19 with severe cognition impairment and required extensive assistance of staff with, bed mobility, dressing, transfers and mobility. During review of R19's medical record it was noted there was a Wound Tracking Form initiated on 1/20/15, which identified R19 with an unstageable, 0.5 cm x 0.3 cm pressure ulcer located on the left ankle. The most recent documentation on this Wound Tracking Form was dated 2/14/15, which identified an unstageable pressure to the left ankle. No wound measurements were documented on 2/14/15. The medical record lacked an assessment of the skin integrity and it's supporting structures to determine how long pressure can be on one area without ill effect. A Braden Scale assessment was conducted on 10/28/14 and identified R19 with a score of 18, indicating a mild risk for pressure ulcer development. The following nursing progress notes were documented: (1) 1/29/15- 3:18 p.m. Resident noted with spa today, per NAR on the 6-2 shift. Resident noted with open area on a heel [which heel, is not specified]. Resident noted with no other skin issues reported today from info sheet received. (2) 2/12/15- 3:06 p.m. Resident noted with spa today, per NAR, on the 6-2 shift. Resident noted with no skin issues reported. Fingernails were clipped only. (3) 2/19/15- 1:10 p.m. Resident had spa today. Tolerated well. Vitals and weight obtained. Ears washed. Peri area washed. Does not shave.	{2 900}		

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{2 900}	Continued From page 22 Fingernails and toenails checked not clipped. Open area remains on left ankle, dressed by nurse. (4) 2/19/15- 11:15 a.m. Round mepilex with center cut out applied to left outer ankle to protect it and wrapped with kerlix. Left outer ankle has been reddened with open area. During observation of morning cares on 2/20/15 at 7:30 a.m. NA-C and NA-R assisted R19 out of bed with the use of a EZ stand mechanical lift. R19 was noted to have a boot on her left ankle when staff uncovered her foot. NA-C stated R19 was dependent of staff to turn and reposition and transfer from the bed.. During observation of R19's left ankle wound on 2/20/15 at 8:05 a.m. with the DON and RN-A present, a dime sized open area on the outer aspect of the left ankle was noted. The wound was dressed with a Mepilex dressing with center cut out and the dressing was covered with gauze. The wound was reddened at the periphery and had drainage noted. The DON and RN-A stated they were not sure whether the Mepilex dressing with the center cut out was making the wound improve or worsen. They stated it looked worse and appeared red in color. R19's care plan identified her at risk for pressure ulcers related to needing extensive assistance with bed mobility and occasional urinary incontinence. Other risk factors for further skin breakdown included: needing assistance with her ADLs including bed mobility, diagnosis-cognitive impairment, needing assistance with her ADLs, decreased communication and history of a PU. The care plan failed to identify that R19 currently had a PU located on the left ankle nor were there any interventions identified related to this condition. During interview with the DON and RN-A on	{2 900}		

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{2 900}	Continued From page 23 2/20/15, at 8:15 a.m. neither staff could locate a physician order for the use of the Mepilex dressing for the wound. The DON verified there had been no reassessment of R19 for pressure ulcer risk after development of the pressure ulcer (1/20/15) and verified the care plan had not been revised to reflect interventions to promote healing and prevent further skin breakdown of the identified PU. Further, the DON stated R19 had a physician order to be seen by physical therapy for a wound treatment evaluation on 1/20/15 but the evaluation had not yet been completed (month later 2/20/15). R19 was identified with a history of pressure ulcers and developed a new PU on the left ankle region. The facility failed to reassess R19's risk factors after development of the PU and failed to identify individualized interventions necessary for staff to implement to prevent further PU breakdown. The treatment utilized had not been ordered by the physician and a wound evaluation by physical therapy ordered by the physician (1/20/15) had not yet been conducted for R19 so that timely treatment was developed and implemented.	{2 900}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QDJW
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: **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 **12/19/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 01/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 2, 2015

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

RE: Project Number S5274024

Dear Ms. Campbell:

On December 19, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 28, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 19, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	12/19/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide ongoing activities for 1 of 3 residents (R3) reviewed for activities. Findings include: R3 was observed on 12/16/14, at 2:05 p.m. seated in the dining room asleep, at a table by himself during coffee hour. During an observation on 12/18/14, at 9:58 a.m. R3 was seated in a wheelchair in the lounge area during a	F 248	1. The care plan goals and interventions for R3 were not changed, but the supporting documentation provided by the Activity Staff was noted to not be taking credit for visits that were either provided by staff or by his wife. Retraining of the activity staff will be provided to more accurately capture the data to support the interventions that are in place to enhance R3's well-being. The existing document for charting these types of visits has an existing line to note when a resident has	1/28/15

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

Electronically Signed | 01/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 1 group activity of trivia/newspaper reading. It was noted the R3 did not participate with the group activity. Due to wearing dark glasses, it was difficult to determine whether R3 was awake or asleep. A subsequent observation on 12/18/14, at 10:58 a.m. noted that R3 was making vocalizations/audible sounds while the "Price is Right" was playing on the TV in the lobby. Audible sounds continued throughout both the commercials and the program. Observation on 12/18/14, at 2:32 p.m. noted that R3 was asleep on his bed and there was no evidence of music playing on the radio while he was in his room. R3's diagnosis identified on the quarterly minimum data set (MDS) dated 10/22/14, was dementia. The brief interview for mental status (BIMS) was identified as 9 which indicated moderate cognitive impairment. The MDS further identified that R3 was totally dependent on staff for locomotion. Diagnoses identified in the care plan dated 11/6/14, noted R3 as legally blind and with hearing impairment. Review of the care plan for R3 dated 11/6/14, identified the following: Focus: R3 is dependent on staff to provide transportation to activities r/t [related to] blindness. R3 also has hearing loss. R3 is often disruptive during activities r/t not understanding what is going on. Goal: R3 will contribute to conversations during 1:1 visits 2-3 x (times) weekly. Interventions: Visit in room 2-3 x weekly. R3 enjoys visiting about farming and the "old days." Ensure KSMU is on in his room as resident enjoys the radio more than music on TV per his wife.	F 248	visitors. 2. There are currently seven (7) residents listed as having care plans with 1:1 visits as an intervention. The activity director is reviewing each plan for effectiveness and appropriate frequency of visit. Also, the retraining for capturing credit for visits, whether provided by staff or visitors will be charted. 3. We will continue to follow the RAI process. Through assessment to determine each resident's individual interests, a care plan will be developed with appropriate goals and interventions for achieving the goals. Periodic measurement of the effectiveness of those interventions will be completed on a minimum of a quarterly basis with revisions to the care plan completed as needed. 4. The Activity Director and her delegates will remain responsible for ensuring that this process is carried out, including updating the care plan. The Activity Director will monitor the charting for 1:1 visits and other supporting documentation/charting for one quarter and report results at the next Quality Assurance meeting.	

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F 248	Continued From page 2 Review of the activity participation record for the months of November and December 2014 revealed that 1:1 staff visits were provided only twice (2 x) in November and documentation was lacking to indicate that any activity staff 1:1 visits had occurred in December 2014. The activity participation record also lacked documentation that music from the radio had been provided in R3's room on 12/18/14. An interview with R3's spouse on 12/18/2014, at 1:52 p.m. verified that activity staff invited and assisted R3 to group activities. She further added that R3 had participated on rare occasions but more frequently just slept thru the group activity. An interview with the activity director on 12/18/14, at 2:37 p.m. verified that activity staff conducted 1:1 staff/R3 visits only twice the month of November 2014 and no 1:1 visits by activity staff had been provided yet in December 2014.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		1/28/15

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F 279	Continued From page 3 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive care plan, which included interventions, after a pressure ulcer was identified for 1 of 1 residents (R20) in the closed record sample. Findings include: R20 was admitted on 8/18/14. Review of the admission minimum data set (MDS) dated 8/25/14 identified R20 as being at risk for pressure ulcers and currently having two stage one pressure ulcers on the spine. The MDS further indicated R20 required physical assistance with positioning, but did not have a positioning program. Review of the weekly wound measurement form dated 9/6/14 indicated R20 was identified with a stage two pressure ulcer on the coccyx that measured 2.2 centimeters (cm) length by 1.8 cm width by 0.1 cm depth. Measurements of the pressure ulcer remained unchanged on 9/21/14. The stage one pressure ulcer to the right spine measured 1.0 cm length by 1.0 cm width. The stage one pressure ulcer to the left spine measured 1.8 cm length by 1.8 cm width. Measurements of the pressure ulcers remained	F 279	1. R20 expired at the facility on 9/22/2014. It was noted in the progress notes that her condition rapidly declined during the 35-days that she was a resident which may contribute to the observations reported in the Summary of Deficiencies related to the skin condition. 2. There are no other residents identified at this time with pressure ulcers. 3. We will continue to follow the Routine Orders for Wound Care which are signed by the resident's physician at admission. These orders state that "physicians may order alternative treatments as appropriate. MD must be notified for all new wounds, significant changes, and non-healing wounds." The routine orders address skin tears, pressure ulcers (Stages I-IV), and infected wounds. We will also continue to apply interventions to prevent reoccurrence. 4. The Director of Nursing and her delegates will remain responsible for ensuring that a comprehensive care plan includes a description of interventions and	

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F 279	Continued From page 4 unchanged on 9/21/14. Review of R20's skin assessment with the most current date of 9/8/14 indicated the resident had been assessed to include interventions of a every 2 hour turning and repositioning program. Review of the most current care plan, indicated R20 was admitted with two pressure ulcers on her back and had risk factors for further skin breakdown. The care plan identified R20 as requiring assistance with positioning. Interventions included; use of bed and wheelchair cushions, monitor and treat breakdown and encourage adequate nutritional intake. The care plan did not address nor include interventions of a positioning program to prevent further breakdown nor did the care plan identify the pressure ulcer to the coccyx area that had been identified on 9/6/14. Interview with registered nurse (RN)-B on 12/19/14, at 1:00 p.m. confirmed the care plan for R20 did not include interventions that were included in the skin assessment to prevent further skin breakdown nor did it identify the new pressure ulcer to the coccyx.	F 279	that the implementation of those interventions is carried out and documented. The plan will be monitored for one quarter and results reported at the next Quality Assurance meeting.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		1/28/15

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F 282	Continued From page 5 Based on observation, interview and document review the facility failed provide activities according to the plan of care for 1 of 3 residents (R3) reviewed for activities. Findings include: R3 had diagnoses on the quarterly minimum data set (MDS) dated 10/22/14, which included dementia, legally blind and hearing impairment. R3 was not provided activities per the plan of care dated 11/6/14, which identified the following: Focus: R3 is dependent on staff to provide transportation to activities r/t [related to] blindness. R3 also has hearing loss. R3 is often disruptive during activities r/t not understanding what is going on. Goal: R3 will contribute to conversations during 1:1 staff visits 2-3 x (times) weekly. Interventions: Visit in room 2-3 x weekly. R3 enjoys visiting about farming and the "old days." Ensure KSMU is on in his room as resident enjoys the radio more than music on TV per his wife. R3 was observed on 12/16/14, at 2:05 p.m. seated in the dining room asleep, at a table by himself during coffee hour. During an observation on 12/18/14, at 9:58 a.m. R3 was seated in a wheelchair in the lounge area during a group activity of trivia/newspaper reading. It was noted the R3 did not participate with the group activity. Due to wearing dark glasses, it was difficult to determine whether R3 was awake or asleep. A subsequent observation on 12/18/14, at 10:58 a.m. noted that R3 was making vocalizations/audible sounds while the "Price is Right" was playing on the TV in the lobby. Audible sounds continued throughout both the	F 282	1. The care plan goals and interventions for R3 were not changed, but the supporting documentation provided by the Activity Staff was noted to not be taking credit for visits that were either provided by staff or by his wife. Retraining of the activity staff will be provided to more accurately capture the data to support the interventions that are in place to enhance R3's well-being. The existing document for charting these types of visits has an existing line to note when a resident has visitors. 2. There are currently seven (7) residents listed as having care plans with 1:1 visits as an intervention. The activity director is reviewing each plan for effectiveness and appropriate frequency of visit. Also, the retraining for capturing credit for visits, whether provided by staff or visitors will be charted. 3. We will continue to follow the RAI process. Through assessment to determine each resident's individual interests, a care plan will be developed with appropriate goals and interventions for achieving the goals. Periodic measurement of the effectiveness of those interventions will be completed on a minimum of a quarterly basis with revisions to the care plan completed as needed. 4. The Activity Director and her delegates will remain responsible for ensuring that this process is carried out, including updating the care plan. The Activity	

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F 282	Continued From page 6 commercials and the program. Observation on 12/18/14, at 2:32 p.m. noted that R3 was asleep on his bed and there was no evidence of music playing on the radio while he was in his room. Review of the activity participation record for the months of November and December 2014 revealed that 1:1 staff visits were provided only twice in the month of November 2014 and there was no documentation for the month of December 2014 which indicated 1:1 visits by activity staff had been provided as defined in the plan of care. The activity participation record also lacked documentation that any music had been provided on the radio while R3 was in the room on 12/18/14. An interview with R3's spouse on 12/18/2014, at 1:52 p.m. verified that activity staff invited and assisted R3 to group activities. She further added that R3 had participated on rare occasions but more frequently just slept thru the group activity. An interview with the activity director (AD) on 12/18/14, at 2:37 p.m. verified that activity staff conducted 1:1 staff visits with R3 only 2 times in November and no 1:1 visits by activity staff had been provided in December 2014. The AD verified the plan of care had not been followed as written.	F 282	Director will monitor the charting for 1:1 visits and other supporting documentation/charting for one quarter and report results at the next Quality Assurance meeting.	
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	F 314		1/28/15

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F 314	Continued From page 7 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 interview and document review the facility failed to implement interventions to prevent further skin breakdown for 1 of 2 residents (R20) reviewed in the closed record sample and identified with pressure ulcers. Findings include: R20 was admitted on 8/18/14. Review of the admission minimum data set (MDS) dated 8/25/14 identified R20 as being at risk for pressure ulcers and currently having two stage one pressure ulcers on the spine. The MDS further indicated R20 required physical assistance with positioning, but did not have a positioning program. Review of the weekly wound measurement form dated 9/6/14 indicated R20 was identified with a stage two pressure ulcer on the coccyx that measured 2.2 centimeters (cm) length by 1.8 cm width by 0.1 cm depth. Measurements of the pressure ulcer remained unchanged on 9/21/14. The stage one pressure ulcer to the right spine measured 1.0 cm length by 1.0 cm width. The stage one pressure ulcer to the left spine measured 1.8 cm length by 1.8 cm width. Measurements of the pressure ulcers remained unchanged on 9/21/14.	F 314	1. R20 expired at the facility on 9/22/2014. It was noted in the progress notes that her condition rapidly declined during the 35-days that she was a resident which may contribute to the observations reported in the Summary of Deficiencies related to the skin condition. 2. There are no other residents identified at this time with pressure ulcers. 3. We will continue to follow the Routine Orders for Wound Care which are signed by the resident's physician at admission. These orders state that "physicians may order alternative treatments as appropriate. MD must be notified for all new wounds, significant changes, and non-healing wounds." The routine orders address skin tears, pressure ulcers (Stages I-IV), and infected wounds. We will also continue to apply interventions to prevent reoccurrence. 4. The Director of Nursing and her delegates will remain responsible for ensuring that a comprehensive care plan includes a description of interventions and that the implementation of those interventions is carried out and	

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F 314	Continued From page 8 Review of the the skin assessment with the most current date of 9/8/14, indicated R20 had a stage one pressure ulcer to the right and left spine and was at risk for further skin breakdown. The assessment further included interventions for R20 that included a every two hour turning and repositioning program. The assessment did not identify the new pressure ulcer to the coccyx. Review of the most current care plan, indicated R20 was admitted with two pressure ulcers on her back and had risk factors for further skin breakdown. The care plan identified R20 as requiring assistance with positioning. Interventions included; use of bed and wheelchair cushions, monitor and treat skin breakdown and encourage adequate nutritional intake. The care plan did not address nor include interventions of a positioning program nor did the care plan identify the pressure ulcer to the coccyx area. Interview with registered nurse (RN)-B on 12/19/14, at 1:00 p.m. confirmed the care plan for R20 did not include interventions that were included in the skin assessment to prevent further skin breakdown nor did it identify the new pressure ulcer to the coccyx.	F 314	documented. The plan will be monitored for one quarter and results reported at the next Quality Assurance meeting.	
F 441 SS=D	.. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		1/28/15

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F 441	Continued From page 9 (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. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure staff washed hands and changed gloves after removal of a urine soaked incontinent product and prior to the provision of oral care for 1 of 1 resident (R11) observed	F 441	A meeting for all nursing personnel is scheduled for January 23, 2015. The agenda will include a review of Infection Control, including the proper way to don and doff gloves and hand washing, during	

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(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 441	Continued From page 10 during morning cares. Findings include: During observation on 12/19/14, at 7:58 a.m. nursing assistant (NA)-B was noted to donn gloves prior to washing and drying R11's face and hands. NA-B proceeded to apply lotion to R11's face and legs while resident was lying in bed. NA-B then assisted R11 to transfer from a lying to sitting position on the edge of the bed and then applied a gait belt to R11's waist. R11 ambulated into the bathroom with NA-B's assistance and the use of a walker. R11 remained in a standing position in front of the toilet while NA-B removed and handled the visibly urine soaked disposable brief. NA-B then placed the folded brief into the plastic lined trash. After R11 was seated on the toilet and without changing gloves, NA-B washed his neck, head, arms and back area with a moistened washcloth. It was observed that NA-B collected R11's toiletries from the bed side stand and applied deodorant to R11's underarms. NA-B then applied lotion to R11's back, arms and hands and assisted with dressing his upper body. Without a change of gloves, NA-B completed the following cares for R11: retrieved a denture cup, brushed the dentures, handed the dentures to R11 for placement, shaved his facial hair using an electric razor and finally applied after shave lotion to the face and neck area. NA-B did not change gloves after removal of a urine soaked incontinent brief and prior to assistance with oral/denture care. During an interview with NA-B on 12/19/14, at 8:32 a.m. she verified the disposable brief was urine soaked when removed from R11 and indicated she was unable to recall whether she	F 441	and after providing personal cares. Personnel who do not attend the meeting will meet individually with the Director of Nursing. The Director of Nursing (DON) and her delegates will continue to be responsible for ensuring proper infection control practices, especially as they relate to preventing the spread of potential illness through the misuse of protective equipment (e.g. gloves) and improper handwashing. The Infection Control Specialist on campus may be consulted as needed for assistance with providing re-education and audits of the system at Lutz Wing. The DON will audit the procedures for proper hand hygiene, including the proper way to don/doff gloves, at least five times a month for the next three months and share her finding at the next Quality Assurance meeting.	

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 _____	12/19/2014

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

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F 441	Continued From page 11 changed her gloves and/or washed her hands during morning cares for R11. During interview on 12/19/14, at 10:30 a.m. the director of nursing (DON) stated she would have expected NA-B to wash her hands before and after providing cares and would expect a change of gloves after contact with a soiled/urine soaked incontinent product.	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review,the facility failed to ensure potable and non-potable water needs for the facility were estimated and planned for, should loss of normal water supply occur. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility's emergency water supply procedure dated 1/24/14 was reviewed. The procedure did not specify a method for distributing potable/ non-potable water or calculations for estimating the gallons of water required daily to meet the needs of the residents and staff should there be a loss of the water supply.	F 466	The facility's policy titled "Utilities Management: Scheduled and Unscheduled Utilities Downtime Procedures - Fairmont" will be updated to include the method for distributing potable and non-potable water and the calculations for estimating the number of gallons of water required daily to meet the needs of the residents and staff in the event of a loss in water supply. The Facilities Director, Site Administrator, and Nursing Home Administrator will continue to be responsible for ensuring that the policy and procedure are in force, including any mutual agreements with vendors are updated, re-calculations of	1/28/15

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F 466	Continued From page 12 During interview on 12/19/14 at 11:00 a.m. the facility environmental service manager indicated the facility had a verbal agreement with Viessen Trucking of Mankato MN, for non-potable water. The environmental manager was unable to provide the date of the arrangements/agreement and/or the amount that would be distributed in the case of water loss. The environmental service manager also confirmed there was no arrangement for distributing/calculating potable or non-potable water if needed in an emergency situation.	F 466	water needs, etc. A review of this information will be presented at the next Quality Assurance meeting.	

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	245274	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/17/2014**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 17, 2014. 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 34 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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
January 2, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5274024

Dear Ms. Campbell:

The above facility was surveyed on December 16, 2014 through December 19, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	12/19/2014

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 16, 17, 18, and 19th 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive care plan, which included interventions, after a pressure ulcer was identified for 1 of 1 residents (R20) in the closed record sample. Findings include: R20 was admitted on 8/18/14. Review of the admission minimum data set (MDS) dated 8/25/14 identified R20 as being at risk for pressure ulcers and currently having two stage one pressure ulcers on the spine. The MDS further indicated R20 required physical assistance with positioning, but did not have a positioning program.	2 560	corrected	1/23/15

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2 560	Continued From page 3 Review of the weekly wound measurement form dated 9/6/14 indicated R20 was identified with a stage two pressure ulcer on the coccyx that measured 2.2 centimeters (cm) length by 1.8 cm width by 0.1 cm depth. Measurements of the pressure ulcer remained unchanged on 9/21/14. The stage one pressure ulcer to the right spine measured 1.0 cm length by 1.0 cm width. The stage one pressure ulcer to the left spine measured 1.8 cm length by 1.8 cm width. Measurements of the pressure ulcers remained unchanged on 9/21/14. Review of R20's skin assessment with the most current date of 9/8/14 indicated the resident had been assessed to include interventions of a every 2 hour turning and repositioning program. Review of the most current care plan, indicated R20 was admitted with two pressure ulcers on her back and had risk factors for further skin breakdown. The care plan identified R20 as requiring assistance with positioning. Interventions included; use of bed and wheelchair cushions, monitor and treat breakdown and encourage adequate nutritional intake. The care plan did not address nor include interventions of a positioning program to prevent further breakdown nor did the care plan identify the pressure ulcer to the coccyx area that had been identified on 9/6/14. Interview with registered nurse (RN)-B on 12/19/14, at 1:00 p.m. confirmed the care plan for R20 did not include interventions that were included in the skin assessment to prevent further skin breakdown nor did it identify the new pressure ulcer to the coccyx.	2 560		

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2 560	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develop care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed provide activities according to the plan of care for 1 of 3 residents (R3) reviewed for activities. Findings include: R3 had diagnoses on the quarterly minimum data set (MDS) dated 10/22/14, which included dementia, legally blind and hearing impairment. R3 was not provided activities per the plan of care dated 11/6/14, which identified the following:	2 565	corrected	1/23/15

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2 565	Continued From page 5 Focus: R3 is dependent on staff to provide transportation to activities r/t [related to] blindness. R3 also has hearing loss. R3 is often disruptive during activities r/t not understanding what is going on. Goal: R3 will contribute to conversations during 1:1 staff visits 2-3 x (times) weekly. Interventions: Visit in room 2-3x weekly. R3 enjoys visiting about farming and the "old days." Ensure KSMU is on in his room as resident enjoys the radio more than music on TV per his wife. R3 was observed on 12/16/14, at 2:05 p.m. seated in the dining room alseep, at a table by himself during coffee hour. During an observation on 12/18/14, at 9:58 a.m. R3 was seated in a wheelchair in the lounge area during a group activity of trivia/newspaper reading. It was noted the R3 did not participate with the group activity. Due to wearing dark glasses, it was difficult to determine whether R3 was awake or asleep. A subsequent observation on 12/18/14, at 10:58 a.m. noted that R3 was making vocalizations/audible sounds while the "Price is Right" was playing on the TV in the lobby. Audible sounds continued throughout both the commercials and the program. Observation on 12/18/14, at 2:32 p.m. noted that R3 was asleep on his bed and there was no evidence of music playing on the radio while he was in his room. Review of the activity participation record for the months of November and December 2014 revealed that 1:1 staff visits were provided only twice in the month of November 2014 and there was no documentation for the month of December 2014 which indicated 1:1 visits by activity staff had been provided as defined in the plan of care. The activity participation record also	2 565		

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2 565	Continued From page 6 lacked documentation that music had been provided on the radio while R3 was in the room on 12/18/14. An interview with R3's spouse on 12/18/2014, at 1:52 p.m. verified that activity staff invited and assisted R3 to group activities. She further added that R3 had participated on rare occasions but more frequently just slept thru the group activity. An interview with the activity director (AD) on 12/18/14, at 2:37 p.m. verified that activity staff conducted 1:1 in room visits with R3 only 2 times in November and no 1:1 visits by activity staff had been provided in December 2014. The AD verified the plan of care had not been followed as written. SUGGESTED METHOD OF CORRECTION: The activity director could educate staff on the importance of the implementation of 1:1 visits for assessed residents. The activity director could monitor for implementation and report to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home	2 900		1/23/15

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2 900	Continued From page 7 without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement interventions to prevent further skin breakdown for 1 of 2 residents (R20) reviewed in the closed record sample and identified with pressure ulcers. Findings include: R20 was admitted on 8/18/14. Review of the admission minimum data set (MDS) dated 8/25/14 identified R20 as being at risk for pressure ulcers and currently having two stage one pressure ulcers on the spine. The MDS further indicated R20 required physical assistance with positioning, but did not have a positioning program. Review of the weekly wound measurement form dated 9/6/14 indicated R20 was identified with a stage two pressure ulcer on the coccyx that measured 2.2 centimeters (cm) length by 1.8 cm width by 0.1 cm depth. Measurements of the pressure ulcer remained unchanged on 9/21/14. The stage one pressure ulcer to the right spine measured 1.0 cm length by 1.0 cm width. The stage one pressure ulcer to the left spine measured 1.8 cm length by 1.8 cm width.	2 900	corrected	

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	00359	A. BUILDING: _____ B. WING _____	12/19/2014

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2 900	Continued From page 8 Measurements of the pressure ulcers remained unchanged on 9/21/14. Review of the the skin assessment with the most current date of 9/8/14, indicated R20 had a stage one pressure ulcer to the right and left spine and was at risk for further skin breakdown. The assessment further included interventions for R20 that included a every two hour turning and repositioning program. The assessment did not identify the new pressure ulcer to the coccyx. Review of the most current care plan, indicated R20 was admitted with two pressure ulcers on her back and had risk factors for further skin breakdown. The care plan identified R20 as requiring assistance with positioning. Interventions included; use of bed and wheelchair cushions, monitor and treat skin breakdown and encourage adequate nutritional intake. The care plan did not address nor include interventions of a positioning program nor did the care plan identify the pressure ulcer to the coccyx area. Interview with registered nurse (RN)-B on 12/19/14, at 1:00 p.m. confirmed the care plan for R20 did not include interventions that were included in the skin assessment to prevent further skin breakdown nor did it identify the new pressure ulcer to the coccyx. .. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the current policy and procedures on pressure ulcers, and could provide education to staff on pressure ulcers. The administrator or designee could provide monitoring for compliance for treatment and prevention of pressure ulcers.	2 900		

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2 900	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure staff washed hands and changed	21390	corrected	1/23/15

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gloves after removal of a urine soaked incontinent product and prior to the provision of oral care for 1 of 1 resident (R11) observed during morning cares.

Findings include:

During observation on 12/19/14, at 7:58 a.m. nursing assistant (NA)-B was noted to donn gloves prior to washing and drying R11's face and hands. NA-B proceeded to apply lotion to R11's face and legs while resident was lying in bed. NA-B then assisted R11 to transfer from a lying to sitting position on the edge of the bed and then applied a gait belt to R11's waist. R11 ambulated into the bathroom with NA-B's assistance and the use of a walker. R11 remained in a standing position in front of the toilet while NA-B removed and handled the visibly urine soaked disposable brief. NA-B then placed the folded brief into the plastic lined trash. After R11 was seated on the toilet and without changing gloves, NA-B washed his neck, head, arms and back area with a moistened washcloth. It was observed that NA-B collected R11's toiletries from the bed side stand and applied deodorant to R11's underarms. NA-B then applied lotion to R11's back, arms and hands and assisted with dressing his upper body. Without a change of gloves, NA-B completed the following cares for R11: retrieved a denture cup, brushed the dentures, handed the dentures to R11 for placement, shaved his facial hair using an electric razor and finally applied after shave lotion to the face and neck area. NA-B did not change gloves after removal of a urine soaked incontinent brief and prior to assistance with oral/denture care.

During an interview with NA-B on 12/19/14, at 8:32 a.m. she verified the disposable brief was

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21390	Continued From page 11 urine soaked when removed from R11 and indicated she was unable to recall whether she changed her gloves and/or washed her hands during morning cares for R11. During interview on 12/19/14, at 10:30 a.m. the director of nursing (DON) stated she would have expected NA-B to wash her hands before and after providing cares and would expect a change of gloves after contact with a soiled/urine soaked incontinent product. Based on interview and document review the facility failed to ensure that 1 of 5 nursing staff (nursing assistant (NA)-C) had a negative test result fo Mycobacterium tuberculosis prior to resident contact per facility policy. This had the potential to affect all 34 residents residing in the facility. Findings include: During review of employee tuberculin skin test (TST) records it was noted that NA-C was initially hired on 03/30/14. A tuberculin screening tool dated 3/10/14 indicated NA-C was born outside the US in Kenya and had visited Kenya in the past 2 years. NA-C did not report to work and was terminated on 4/25/14. On 8/3/14, it was noted that NA-C was rehired by the facility. A blood assey mycobacterium tuberculosis (BAMT) test was completed on 8/4/14 and the result indicated that NA-C had a positive (+) tuberculin test result. Documentation was lacking to indicate that NA-C had been referred to either his private physician or the local public health department for follow-up and potential treatment per facility policy. A letter from the physician or local public health department attesting to the non-infectious nature of the applicant must be	21390		

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received prior to date of hire according to facility policy. This letter was not available for review.

On 12/19/14, at 11:30 a.m. during an interview with the director of nursing (DON) it was verified that she would expect an employee to have documentation of a negative TST prior to beginning orientation on the unit and having contact with residents. The DON further verified that NA-C was an on-call employee and did not have a regular schedule. Review of the timecard with the DON indicted NA-C had worked on the unit with resident contact on the following dates (8 shifts): 8/25/14, 8/26/14, 8/27/14, 9/1/14, 9/14/14, 9/15/14, 9/16/14 and 9/26/14. The DON indicated she was unaware that NA-C had a positive result from the BAMT blood test.

Review of the facility policy titled, Tuberculosis Control Plan with an approved date of 11/18/14 indicated: The organization has adopted and will enforce the latest recommendations of the centers for disease control and prevention (CDC) regarding prevention of occupational transmission of tuberculosis (TB) among its employees;
pg (5)- Prospective Employees (on hire) Screening: 1.) All individuals that have been offered a position will be screened for the presence of infection with m. tuberculosis using the tuberculin skin test (TST) for baseline testing or blood assay for mycobacterium tuberculosis (BAMT) (e.g. QuantiFeron). 2.) TB screening prior to hire and as recommended thereafter is a condition of employment. 3.) If skin testing is utilized, a two-step procedure will be implemented. 4.) Individuals with a positive TST(>10 mm) or BAMT will be referred either to their private physician or the local public health department for follow-up and potential treatment. A letter from the physician or local public health

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21390	Continued From page 13 department attesting to the non-infectious nature of the applicant must be received prior to date of hire. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies to ensure proper infection control procedures were followed during resident cares. The director of nursing could educate nursing staff on infection control procedures. The director of nursing could monitor staff compliance. The director of nursing could ensure the proper screening requirements have been completed for new employees prior to contact with residents. An audit could be developed and the results reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced	21435		1/23/15

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21435	Continued From page 14 by: Based on observation, interview and document review the facility failed to provide ongoing activities for 1 of 3 residents (R3) reviewed for activities. Findings include: R3 was observed on 12/16/14, at 2:05 p.m. seated in the dining room alseep, at a table by himself during coffee hour. During an observation on 12/18/14, at 9:58 a.m. R3 was seated in a wheelchair in the lounge area during a group activity of trivia/newspaper reading. It was noted the R3 did not participate with the group activity. Due to wearing dark glasses, it was difficult to determine whether R3 was awake or asleep. A subsequent observation on 12/18/14, at 10:58 a.m. noted that R3 was making vocalizations/audible sounds while the "Price is Right" was playing on the TV in the lobby. Audible sounds continued throughout both the commercials and the program. Observation on 12/18/14, at 2:32 p.m. noted that R3 was asleep on his bed and there was no evidence of music playing on the radio while he was in his room. R3's diagnosis identified on the quarterly minimum data set (MDS) dated 10/22/14, was dementia. The brief interview for mental status (BIMS) was identified as 9 which indicated moderate cognitive impairment. The MDS further identified that R3 was totally dependent on staff for locomotion. Diagnoses identified in the care plan dated 11/6/14, noted R3 as legally blind and with hearing impairment. Review of the care plan for R3 dated 11/6/14, identified the following: Focus: R3 is dependent on staff to provide	21435	corrected	

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21435	Continued From page 15 transportation to activities r/t [related to] blindness. R3 also has hearing loss. R3 is often disruptive during activities r/t not understanding what is going on. Goal: R3 will contribute to conversations during 1:1 visits 2-3 x (times) weekly. Interventions: Visit in room 2-3 x weekly. R3 enjoys visiting about farming and the "old days." Ensure KSMU is on in his room as resident enjoys the radio more than music on TV per his wife. Review of the activity participation record for the months of November and December 2014 revealed that 1:1 staff visits were provided only twice (2 x) in November and documentation was lacking to indicate that any activity staff 1:1 visits had occured in December 2014. The activity participation record also lacked documentation that music from the radio had been provided in R3's room on 12/18/14. An interview with R3's spouse on 12/18/2014, at 1:52 p.m. verified that activity staff invited and assisted R3 to group activities. She further added that R3 had participated on rare occasions but more frequently just slept thru the group activity. An interview with the activity director on 12/18/14, at 2:37 p.m. verified that activity staff conducted 1:1 staff/R3 visits only twice the month of November 2014 and no 1:1 visits by activity staff had been provided yet in December 2014. SUGGESTED METHOD FOR CORRECTION: The activity director and/or designee could review/revise policy and provide education for staff regarding resident activities. The Quality Assessment and Assurance (QAA) committee	21435		

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21435	Continued From page 16 could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21435		