DEPARTMENT OF HEALTH AN	ND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: QDJW
	PART I -	TO BE COMPL	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00359
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245274     2.STATE VENDOR OR MEDICAID NO.     (L2) 259845104	Э.	3. NAME AND AD (L3) MAYO CLIN (L4) 800 MEDICA (L5) FAIRMONT	NIC HEALTH AL CENTER I	SYSTEM		<ol> <li>TYPE OF ACTION: <u>7</u>(L8)</li> <li>Initial</li> <li>Recertification</li> <li>Termination</li> <li>CHOW</li> <li>Validation</li> <li>Complaint</li> </ol>
	EDGUID		,			7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 03/19/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	)15 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	07 ESKD 10 NF 11 ICF/III 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) <b>09/30</b>
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit
12. Total Facility Beds	<b>40</b> (L18)	-	e Based On: cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	<ul> <li>T. Medical Director</li> <li>Weiter Room Size</li> <li>9. Beds/Room</li> </ul>
13.Total Certified Beds	<b>40</b> (L17)		pliance with Prog ents and/or Applie			(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
40 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS See Attached Remarks	S (IF APPLICA	ABLE SHOW LIC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Joseph Garvey, HFE NE II		0	3/25/2015	(L19)	Kamala Fiske-Downing	<u>, Enforcement Speciali</u> st 04/07/2014 (L20)
PART I	I - TO BE	COMPLETED F	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBILITY         _X1. Facility is Eligible to Particip        2. Facility is not Eligible	pate (L21)		PLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :
	. ,				1	
	LTC AGREE!	MENT 24	. LTC AGREEM	IENT	26. TERMINATION ACTION	, , , , , , , , , , , , , , , , , , ,
OF PARTICIPATION <b>04/01/1985</b>	BEGINNINC	G DATE	ENDING DAT	ΤE	VOLUNTARY     00       01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	oo run to moorrigicoment
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
(	L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
(1	L32)	01/27/2015		(L33)	DETERMINATION APP	ROVAL

## 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

#### 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.



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,

Kumala Fiske Downing

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

cc: Licensing and Certification File



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,

Kumala Fiske Downing

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

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245274	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 3/19/2015		
Name of Facility		Street Address, City, State, Zip Code				
M	AYO CLINIC HEALTH SYSTEM - FAIF	RMONT	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	(Y!	5) I	Date
	F0280 483.20(d)(3), 483.10(k)(		ID Prefix Reg. # LSC	F0314 483.25(c)	Correction Completed 03/19/2015		F0520 483.75(o)(1)		Correction Completed 03/19/2015
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed -				Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed				Correction Completed
Reg. #						D //			
Reviewed E	3y Reviewed	ву	Date:	Signature of Su	rveyor:		D	ate:	
State Agen Reviewed E CMS RO		I By	03/25/201 Date:	5 Signature of Su		113	D	<u>03</u> ate:	8/19/2015
Followup t	o Survey Completed or 12/19/2014	1:		Check for any Unco Uncorrected Defi				YES	NO



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,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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 HEALT						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: QDJW
	PART I -	TO BE COMPI	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00359
1. MEDICARE/MEDICAID PROVID (L1) 245274	ER NO.	3. NAME AND AE (L3) MAYO CLIN	NIC HEALTH	SYSTEM		<ul> <li>4. TYPE OF ACTION: <u>7</u>(L8)</li> <li>1. Initial</li> <li>2. Recertification</li> </ul>
2.STATE VENDOR OR MEDICAID (L2) 259845104	NO.	(L4) 800 MEDIC. (L5) FAIRMONT		DRIVE, I	PO BOX 800 (L6) 56031	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 02/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>20/2015</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complian			And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements		2. Technical Personnel	
12.Total Facility Beds	<b>40</b> (L18)	•	e Based On: cceptable POC		3. 24 Hour RN    4. 7-Day RN (Rural SN    5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>WF) 8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>
13.Total Certified Beds	<b>40</b> (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Applie			(L12)
14. LTC CERTIFIED BED BREAKDO	OWN	•			15. FACILITY MEETS	
18 SNF 18/19 SNF 40	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
_Joseph Garvey, HFE	NE II	0	3/05/2015	(L19)	Kamala Fiske-Downing, I	Enforcement Specialist 03/27/2015 (L20)
PA	RT II - TO BE	COMPLETED H	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBII</li> <li> 1. Facility is Eligible to I</li> <li> 2. Facility is not Eligible</li> </ol>	Participate		PLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE						(† 20)
	23. LTC AGREEN BEGINNING		ENDING DAT		26. TERMINATION ACTION VOLUNTARY <u>0</u>	
OF PARTICIPATION <b>04/01/1985</b>	BEGINNING	JAIE	ENDING DAI	LE	01-Merger, Closure 02-Dissatisfaction W/ Reimburs	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	ND
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	07 <u>OTHER</u> 07-Provider Status Change
	A. Suspension	n of Admissions:	(L44)			00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)	01/27/2015		(L33)	DETERMINATION APP	ROVAL

# 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

#### 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.



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 SupervisorMinnesota Department of Health1400 E. Lyon StreetMarshall, Minnesota 56258Kathryn.serie@state.mn.usOffice: (507) 476-4233Fax: (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumalu Fiske Downing

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

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245274	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 2/20/2015		
Name of Facility		Street Address, City, State, Zip Code				
M	AYO CLINIC HEALTH SYSTEM - FAIF	RMONT	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 Reg. #	F0248 483.15(f)(1)	Correction Completed 01/28/2015	ID Prefix Beg. #		Correction Completed 01/28/2015		efix <b>F0282</b> g. # <b>483.20(k)(3)(</b>	ii)	Correction Completed 01/28/2015
					-		SC		
ID Prefix Reg. # LSC		Correction Completed 01/28/2015	ID Prefix Reg. #		Correction Completed 01/28/2015	ID Pr	efix		Correction Completed
ID Prefix Reg. # LSC					Correction Completed		efix g. # SC		Correction Completed
Reg. #			Reg. #		Correction Completed		efix g. # SC		Correction Completed
Dec #			D //			_	efix g. # SC		
Reviewed I	By Rev	iewed By	Date:	Signature of Su	rveyor:			Date:	
State Agen		S/kfd	03/05/20	015	28	591		C	2/20/2015
Reviewed E CMS RO		iewed By	Date:	Signature of Su				Date:	
Followup t	o Survey Complet 12/19/20			Check for any Unco Uncorrected Defi				YES	NO

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY IPLETED
		245274	B. WING				R <b>20/2015</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	20/2013
				80	00 MEDICAL CENTER DRIVE, PO BOX 800	)	
	LINIC HEALTH SYSTE	EM - FAIRMONT		F	AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 00	00}			
F 280 SS=D	completed on 2/19/ certification tags that found on the CMS2 that were not found were issued at the to located on the CMS2 Because you are en- signature is not req page of the CMS-29 submission of the F verification of comp Upon receipt of an on-site revisit of you validate that substat regulations has bee your verification. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incapacitated under participate in plannic changes in care and A comprehensive asso interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance. acceptable electronic POC, an ur facility will be conducted to untial compliance with the en attained in accordance with 0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F 2	280			3/13/15
		DER/SUPPLIER REPRESENTATIVE'S SIGI			דודו ה		(X6) DATE
	ically Signed	LIVOURTLIEN NERNESENTATIVES SIGI	VALURE		TITLE		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.

		AND HUMAN SERVICES	1			FORM	03/31/2015 APPROVED 0938-0391
-	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC		COM	E SURVEY PLETED <b>R</b>
		245274	B. WING				_ 20/2015
	PROVIDER OR SUPPLIER	EM - FAIRMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORREC H CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	and revised by a te each assessment. This REQUIREMEN by: Based on observat review the facility fa care plan for 3 of 3 reviewed who had fulcers. Findings include: R29 was admitted of diagnoses listed on fibrillation, cerebrow vascular disease (F On 2/19/15, at 12:0 the director of nursi pressure ulcer (PU) region which was a facility. During observation at 6:46 a.m. NA-A r	e; and periodically reviewed am of qualified persons after NT is not met as evidenced tion, interview and document ailed to revise and update the residents (R29, R7 and R19) facility acquired pressure on 12/11/12 and current the care plan included: atrial vascular disease, peripheral PVD) and hypertension. D5 p.m. R29 was identified by ing (DON) to have a stage 2 ) on the outside right ankle cquired (1/6/15)while at the of morning cares on 2/20/15, removed a long body pillow	F 2	This plan findings i certificati Assistand response by Mayo noncomp an agree Clinic He its right to entirety a action. M System-F request f for certai F280 The care 2/20/201 reflect the	n and response to the s written solely to main ion in the Medicare an ce Programs. These we as do not constitute an Clinic Health System- bliance with any require ment with any finding. walth System-Fairmont o dispute these finding at any time and in any Mayo Clinic Health Fairmont may submit a for Informal Dispute Re n findings.	ntain d Medical written a dmission Fairmont of ement nor Mayo reserves gs in their legal a separate esolution	
	her in a right side ly observation staff re foot region and the noted covered with evidence of a foot k removed. When sta location of the boot	back, which had maintained ving position. During the moved R29's blanket from her right foot and ankle area was gauze. There was no boot when the covers were aff were questioned about the r, NA-A pointed on top of net and the boot was on top of		category on right s state: "Pr orders, u w/c cush placemen S&S of s	cluding information un of "problem" stating, " side". The current inte ressure ulcer care per ise of air mattress on h ion with soft-backed w nt bid, monitor and tre kin irritation and/or bre ge adequate nutritiona	'likes to lay erventions doctor's her bed and //c, check at early eakdown,	

Facility ID: 00359

If continuation sheet Page 2 of 23

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245274	B. WING			3
	PROVIDER OR SUPPLIER	245214		STREET ADDRESS, CITY, STATE, ZIP C		20/2015
	LINIC HEALTH SYSTE	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 280	the cabinet. NA-A s the boot off. It was ankle was resting o when in the right sid During review of R2 noted on a Wound identified with a uns located on the right 0.5 x 0.5 centimete Tracking Form doc wound continued to circumference and when last documen The care plan dated was at risk for PU r assistance with bed risk for pressure ut included: needs as daily living (ADLs), decreased commun history of pressure occasional urinary i identified on the ca encourage adequat	<ul> <li>dated R29 frequently kicked also noted that R29's right on the mattress of the bed de lying position.</li> <li>29's medical record it was Tracking Form that R29 was stageable pressure ulcer couter ankle which measured rs (cm) on 1/6/15. The Wound umentation identified the ankle o increase in size (1.0 cm) was identified as a stage 2 PU need on 2/14/15.</li> <li>d 1/20/15, identified that R29 related to needing staff d mobility, weight loss and at cers. Other risk factors ssistance with all activities of has cognitive impairment, nication, intermittent pain, ulcers, diagnosis and incontinence. Interventions re plan included: (1) te nutritional intake; (2) offer</li> </ul>	F 28	offer 240 mL Ensure bid, m pain medications as ordere clean and dry, barrier crean exposed to incontinence, er mobility, use of boot to keep (of ankle), reposition every PRN, and notify doctor if we signs/symptoms of infection The care plan for R7 was u 2/20/2015 by the MDS Coo reflect the current PU on co right buttock. In addition to doctor's order dated 2/21/19 right buttock ulcer apply sm aquacell and cover with me 4x4 foam change every 3 d every 72 hours for pressure current interventions state: policies/protocols for the prevention/treatment of skir monitor nutritional status. S ordered, monitor intake and Juven supplement two time wound healing, reposition e and PRN, the resident requ Navy blue w/c cushions, ch	d, keep skin n to areas neouraging o pressure off two hours and orsens or n". pdated on rdinator to occyx, below following the 5 of "below hall amt pilex bordered ays et pm e ulcer", the "follow facility n breakdown, Serve diet as d record, offer es per day for overy 2 hours ires bed and eck placement	
	monitor and treat e symptoms) of skin the use of air mattr of a wheelchair cus wheelchair. The ca revised/reviewed of failed to identify tha ulcer. Interventions plan related to an ir schedule, the ident	oplement) twice daily; (3) arly S&S (signs and irritation and or breakdown; (4) ess on her bed; and (5) a use shion with soft backed are plan was last n 8/5/14 for PU risk and it tt R29 had an active pressure were not evident on the care ndividualized repositioning ification of the type of or that utilized a boot on her		bid." R7's PU was noted as 3/7/2015. The care plan wa reflect interventions focusin ulcer prevention, including, reposition every 2 hrs, Juve in chair, and air mattress or The care plan for R19 was 2/20/2015 by the Charge Ni current PU located on the " malleolus". The newest inte ordered by physician were of the wound therapist on 3/11	as updated to g on pressure "turn and en tid, cushions n bed". updated on urse to reflect left lateral erventions completed by	

Facility ID: 00359

If continuation sheet Page 3 of 23

		AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	SURVEY PLETED
		245274	B. WING _		F 02/2	≀ 20/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
MAYO C	LINIC HEALTH SYSTI	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, FAIRMONT, MN 56031	PO BOX 800	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 3	F 28			
	DON verified there update documented that any additional implemented since	on 2/19/15, at 1:02 p.m. the had not been a revision nor d on the care plan to identify interventions that had been the identification of the nd which had increased in		On 3/11/2015, the DON is residents for pressure us residents with a pressure at high risk for skin breal reviewed the resident s confirm that it reflects the and/or the resident s ris breakdown and all current	cers. For those e ulcer or who are kdown, the DON care plan to e pressure ulcer sk for skin	
	listed on the care p bladder, history of f sclerosis (MS), hist	0/13 and had active diagnoses lan which included: neurogenic foot ulcer, stage 2, multiple cory of low back pressure ulcer, pressure ulcer, malaise and	luded: neurogenic ge 2, multipleprovide education regarding the organization s Pressure Ulcerck pressure ulcer,Management and Treatment Policy a		ling the Ulcer nent Policy and, on of pressure and associated	
	Tracking Form date stage 2 PU. The for which identified the identified the wound open area with red bed. There was no of the Wound Track	dical record revealed a Wound ed 2/7/15 identified R7 with a orm lacked documentation location of the PU but d size as a 0.8 cm x 2.5 cm drainage and a pink wound o further documentation on any king Forms since 2/7/14 to as of the PU, whether it had orsened.		Lutz Wing RN staff on M this time, staff competen assessed via a test. By N the Director of Nursing w all RN staff individually to organization s Pressure Management and Treatm set expectations regardin documenting on resident	arch 13, 2015. At cy will be March 13, 2015, vill also meet with preview the Ulcer nent Policy and ng updating and	
	During observation at 5:57 a.m. R7 wa her back (supine po position. At 6:19 a.n assist R7 out of ber to assist with the tra an EZ stand mecha cares, at 6:24 a.m. R7 on the edge of h attached the support transfer R7 from th	of resident cares on 2/20/15 s observed lying on her bed on osition) with the bed in the low m. NA-A entered room to d and at 6:21 a.m. NA-C joined ansfer from bed with the use of anical lift. After completion of NA-A and NA-C positioned her bed in seated position and ort belt from the lift swing to e bed into the bathroom. n the toilet, it was observed		The Director of Nursing, with the MDS coordinato audits of all resident care records for residents with are completed weekly fo beginning March 13, 201 reported out quarterly at meetings, beginning with 2015 meeting. After six r Director of Nursing, Nurse Administrator, and Nurse will reassess the need for	r, will ensure that e plans and h pressure ulcers r six months, 5. Results will be Lutz Wing QA h the April 15, months, the sing Home e Administrator	

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If continuation sheet Page 4 of 23

	-	AND HUMAN SERVICES			FORM	03/31/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245274	B. WING			R <b>20/2015</b>
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTE	EM - FAIRMONT		00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa that R7 had a 4 x 4 gluteal fold. When was painful R7 state but not right now". R7's last revised ca identify the gluteal f revise and modify a PU. This care plan remain free of furth identified her at risk to medications, ADI decreased range of diagnosis. However revised and modifie of the resident. During interview wit 2/20/15, at 8:10 a.m had not been revise R19 was admitted of diagnoses listed on history of transische history of malignant During review of R1 noted there was a V 1/20/15 which ident measured 0.5 cm x ankle. The Wound documented on 2/1 unstageable PU on During observation 7:30 a.m. NA-C and bed with the use of	age 4 dressing applied to the right questioned whether the area ed, "It hurts when I sit too long are plan dated 1/19/15 failed to fold PU (2/8/15) and failed to any interventions related to the identified that R7 would er skin breakdown and k for PU development related L needs, bowel incontinence, f motion, pain and medical r, the care plan had not been ed to reflect the current status th the DON and RN-A on n. it was verified the care plan ed and/or modified. on 8/14/13 and had current the care plan which included: emic accident, hypertension, t neoplasm and dementia. 19's medical record it was Mound Tracking Form initiated tified an unstageable PU a 0.3 cm and located on the left Tracking Form was last 4/15 which identified an the left ankle. of a.m. cares on 2/20/15 at d NA-R assisted R19 out of a EZ stand mechanical lift.	F 280			
	bed with the use of R19 was noted to h					

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If continuation sheet Page 5 of 23

		AND HUMAN SERVICES				FORM	: 03/31/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	COM	E SURVEY IPLETED R
		245274	B. WING				n 20/2015
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTI	EM - FAIRMONT			IEDICAL CENTER DRIVE, PO BOX 80 MONT, MN 56031	D	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	Continued From pa	ige 5	F 2	80			
	was dependent of s transfer out of bed.	staff to turn and reposition and					
{F 314} SS=G	related to needing of mobility and occasi Other risk factors for included-needing a including bed mobili impairment, needin decreased commun pressure ulcer. The that R19 had a current the left ankle (1/20/ revisions and modil the current PU. During interview wi 2/20/15, at 8:15 a.m physician order for dressing for the wo the care plan had m interventions to pro- further skin breakd had the current treat care plan. 483.25(c) TREATM PREVENT/HEAL P Based on the composition resident, the facility who enters the facility	RESSURE SORES orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and	{F 31	4}			3/16/15

Facility ID: 00359

If continuation sheet Page 6 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 03/31/2015 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245274	B. WING	i		R <b>02/20/2015</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT			00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
{F 314}	Continued From pa	ge 6	{F 3	14}		
	by: Based on observat review, the facility facomprehensive reaulcers were identified monitored and provi- healing, and failed to prevent further deteo of new pressure ulcers R7, R19) reviewed pressure ulcers, an pressure ulcers, an pressure ulcers, an pressure ulcers. The actual harm for R29 Findings include: R29 had a history of developed an unsta on 1/6/15, which ind (centimeters) to 1.0 receive the treatme physician, nor were implemented include affected foot. In addreassessment had subsequent interve healing and preven practice resulted in R29 was admitted to current diagnoses I included: atrial fibril disease, peripheral hypertension.	ssessment when pressure ed, failed to ensure staff rided care that promoted to develop measures to erioration and reduce the risk ters for 3 of 3 residents (R29, who had facility acquired d who all had a history of ese deficient practices caused			F314 On 3/12/2015, the Charge Nurse completed a skin integrity reassess on the pressure ulcer on R29 s ou right ankle and documented the find and contributing factors on the seco page of the assessment tool. The O Nurse documented the existence of pressure ulcer in R29 s care plan. DON confirmed that the physician of for the Tincture of Benzoin and flee boot are part of the medical record that direct care staff were instructed/trained on the implement of the orders. The Wound Tracking is expected to be updated with wee entries. The Tissue Tolerance eval will be completed on 3/15/2015 whi assist in determining a repositioning for R29. The DON communicated interventions, including the Tincture Benzoin, fleece boot, individualized repositioning schedule, etc. to direct staff and documented the interventi R29 s care plan. The DON notifie R29's family and physician regardin status of the pressure ulcer on 3/12 R7's PU was noted as healed on 3/7/2015. On 3/12/2015, the Charg Nurse completed a skin integrity assessment and documented the fi on the second page of the assessm tool. The care plan was updated to	ter dings ond Charge f the The orders ce and tation g form kly uation ch will g plan all e of et care ions in d ng the 2/2015.

Facility ID: 00359

If continuation sheet Page 7 of 23

EFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		A. BUILDING	â	R	
	245274	B. WING		02/20/2015	
DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/20/2010	
HEALTH SYST	EM - FAIRMONT		-		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLÉTIO	
ntinued From pa	age 7	{F 314	}		
DS) assessment uired extensive bed mobility, to the second mobility, to the se	t dated 1/7/15, indicated R29 assistance of one to two staff ransfer, mobility, dressing and Interview for Mental Status 29 had a score of 12, nitive impairment. The r identified that R29 had an ure ulcer (PU) on her right g record review it was had a history of pressure led a stage 2 PU (Partial ermis presenting as a shallow ed-pink wound bed without her middle coccyx region 1/14. 05 p.m. R29 was identified by ing (DON) to have a stage 2 right ankle region which was 1/6/15) while at the facility. note documentation dated that R29 complained of pain on e and staff discovered a 0.5 with peripheral redness and a had been subsequently applied was no further documentation cabbed area identified in the il 1/6/15, when the unstageable right outer ankle was identified. ical record review it was noted ing Form that R29 was nstageable PU located on the hich measured 0.5 x 0.5	{⊢ 314	<ul> <li>interventions focusing on pressurprevention, including, "turn and revery 2 hrs, Juven tid, cushions i and air mattress on bed".</li> <li>On 3/12/2015, the DON complete integrity reassessment on the prevulcer on R19 s left outer ankle a documented the findings and confactors on the second page of the assessment tool and noted complete assessment tool and noted completed on 3/15/2015 which we in determining a repositioning pla R19. The DON confirmed that the physician order for wound treatme evaluation by the physical therap documented in the nurses notes the order had been implemented DON communicated all intervent documented in the care plan and physician's orders to direct care s 1/20/2015, the Charge Nurse not R7 s family and on 2/25/2015 the physician was notified regarding status of the pressure ulcer and the updated, individualized plan of calinterventions.</li> </ul>	eposition n chair, ed a skin essure and trributing e bletion of tes. The xistence are plan. will be ill assist an for ne ent and ist was and that . The ions as staff. On iffied e the the are and Ulcer cy. The	
	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR L DS) assessmen uired extensive bed mobility, to eting. The Brief MS) indicated R ficating mild cog essment furthe stageable pressing thified that R29 ers which includ kness loss of do en ulcer with a R29 ers which includ kness loss of do en ulcer with a r0 ugh) located on ch healed on 5/ 2/19/15, at 12:0 director of nurs on the outside f ently acquired ( rsing progress r 4/14, identified to right outer ankl scabbed area w ymer dressing h he area. There ated to the red s dical record unt located on the f a Wound Track ntified with an u at outer ankle with	RRECTION IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:       A. BUILDING         245274       B. WING	ARRECTION         IDENTIFICATION NUMBER:         A. BUILDING           245274         B. WING           IDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           2 HEALTH SYSTEM - FAIRMONT         STREET ADDRESS, CITY, STATE, ZIP CODE           300 MEDICAL, CENTER DRIVE, PO BOX & FAIRMONT, MN 56031         STREET ADDRESS, CITY, STATE, ZIP CODE           301 SUMMARY STATEMENT OF DEFICIENCIES         D           (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PROVIDERS PLAN OF CORRECT           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG           This det date 1/7/15, indicated R29         interventions focusing on pressure in bed mobility, transfer, mobility, dressing and taig. The Brief Interview for Mental Status           MS) indicated R29 had a score of 12, cating mild cognitive impairment. The essment further identified that R29 had an itageable pressure ulcer (PU) on her right rear ankle. During record review it was notified that R29 had a history of pressure arkin brief interview tor Preventing as a shallow in ucer wink a red-pink wound bed without gif) located on fight outer ankle a stage 2 on the outside right ankle region which was ensing arcquired (1/6/15) while at the facility.           'sing progress note documentation right outer ankle and staff discovered a 0.5 scabed area with peripheral redness and a guered reasing had been subsequently applied her area. There was no further documentation right outer ankle was identified in the discling form that R29 was intified with an unstageable PU located on the right outer ankle was noted a Wound Tracking Form that R29 was intified with an unstageable PU locate	

Facility ID: 00359

If continuation sheet Page 8 of 23

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
			A. BUILDII	NG _		R	
		245274	B. WING _			02/20/2015	
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTI	EM - FAIRMONT			0 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031	)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
{F 314}	Continued From pa	age 8	(E 31	4١			
[F 314]	area on her right ar swollen and measu ankle. The note ind Mepilex dressing, c wrapped with kerlix since 2/14/15 entry A Braden Scale ass determine risk for p was conducted on R29 had a score of of developing press medical record lack integrity and it's sud determine how long without ill effect. During an interview DON stated there h reassessment relat R29 and verified th documented on the additional intervent since the identificat ulcer/wound which When interviewed on nursing assistant (fi in the a.m. (mornin breakfast and then stated R29 repositi not reposition her u assistance even the required staff assis When NA-B was qu	lentified that R29 had an open hkle that appeared red and ured as a 1.0 cm open area on licated staff had reapplied a doubled, with a cut open area, and no further documentation	{F 31	4}	development." On 3/11/2015, a list residents with current skin wounds established. Their medical records examined to confirm the presence necessary skin integrity assessmen physician orders for treatment, wou tracking sheets kept current, and evidence that the protocol are being followed by direct care staff. All residents' skin integrity is asses upon admission, quarterly, and with significant changes by an RN. Tho are at risk for skin breakdown due identified risk factors in the assess are monitored more closely. An integrative at the Lutz Wing will be ad the Pressure Ulcer Management at Treatment Policy to provide that a licensed nurse will conduct a skin in assessment of all residents at leas weekly, ideally during the resident and document the assessment in th Nurse Progress Notes. Each reside skin has the potential to be monitor during daily cares by Nursing Assis They are instructed to inform the C Nurse of concerns. Negative developments with regard to a reside pressure ulcer will be communicated the Charge Nurse to the resident at treating physician and the family/responsible individual. Upor identification of a pressure ulcer, the Charge Nurse will conduct a skin in assessment to determine the sever	was swere of nts, and g sed n se who to the ment ernal ded to nd ntegrity t s bath he ent s red tants. harge dent s ed by s	

Facility ID: 00359

If continuation sheet Page 9 of 23

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB	NO. (	PPROVEI )938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPL	
		245274	B. WING _			R 02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER		l I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	0_/_	
MAYO C	LINIC HEALTH SYSTI	EM - FAIRMONT			00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIOI DATE
{F 314}	after lunch, and in t that R29 was repose During observation at 6:46 a.m. NA-A r from behind R29's her in a right side ly observation, staff re her foot region and was observed to be was no evidence of covers were remov questioned about th pointed to the top of the boot was obser NA-A stated R29 fr was also noted that on the mattress of right side lying posi The care plan date was at risk for PU r assistance with beo risk for pressure uk included: needs as	of morning cares on 2/20/15, removed a long body pillow back, which had maintained ving position. During the emoved R29's blanket from the right foot and ankle area e covered with gauze. There f a foot boot in place when the red. When staff was ne location of the boot, NA-A of R29's clothing cabinet and ved on the top of the cabinet. equently kicked the boot off. It t R29's right ankle was resting the bed when positioned in the tion.	{F 31	4}	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, th nurse will transmit the order to the pharmacy. Nursing Practice and Education staff w provide education regarding the organization s updated Pressure Ulce Management and Treatment Policy to Lutz Wing RN staff on March 13, 2015. this time, staff competency will be assessed via a test. By March 13, 2015. Director of Nursing will also meet with a 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 w	rill r . At 5, all d	
	decreased commun history of pressure occasional urinary identified on the ca encourage adequa 240 ml (milliliters) E daily; (3) monitor an symptoms) of skin use of air mattress wheelchair cushion The care plan failed	has cognitive impairment, nication, intermittent pain, ulcers, diagnosis and incontinence. Interventions re plan included: (1) te nutritional intake; (2) offer Ensure (supplement) twice nd treat early S&S (signs and irritation and or breakdown; (4) on bed; and (5) use of a with soft backed wheelchair. d to identify that R29 had a interventions were identified			pressure ulcers are completed weekly 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, Nursir Home Administrator, and Nurse Administrator will reassess the need fo further audits. Completion Date: 3/16/2015	for t n	

Facility ID: 00359

		& MEDICAID SERVICES			OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY
			A. BUILDIN	G		R
		245274	B. WING		02/2	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BOX 8 FAIRMONT, MN 56031	300	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
{F 314}	based on a compre- identification of treat was supposed to be When interviewed of registered nurse (R physician order for sleep (HS) to preve- stated R29 had a p for use of Tincture of pad applied over th ankle area. Howev Mepilex foam dress applied gauze over dressing was chang days. RN-A also ver physician order for RN-A verified she w comprehensive reat the PU nor were the evident on the care nurse should have reflect the condition assessed the woun interventions could implemented. When interviewed of charge nurse/RN-B a PU, it would be no Tracking Form wou identification of the the wound book, ar notified. RN-B cont	lualized repositioning schedule hensive reassessment, the timents utilized, nor that a boot e applied to the foot at night. on 2/20/15, at 7:30 a.m. N)-A stated R29 had a use of a fleece boot at hour of int pressure. RN-A further hysician order dated 1/8/15, of Benzoin and a thick corn e PU located on the right outer er, RN-A stated staff utilized a sing with the center cut out and the dressing. RN-A state the ged as needed and every 3 erified there was no specific this particular treatment. vas unable to locate any ssessment after discovery of ere any PU interventions plan. RN-A stated the charge updated the care plan to a of R29 and should have d so that individualized be developed and on 2/20/15, at 7:40 a.m. stated that upon discovery of leasured and the family and tified. RN-B stated a Wound ld be initiated, the PU would be documented in ad the DON would also be firmed there had been no ssessment completed related	{F 314	· · · ·		

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STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039		
			A. BUILDII	NG	CO	APLETED R		
		245274	B. WING _		02/20/20			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
МАҮО С	LINIC HEALTH SYSTE	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
{F 314}	accurately reflect a stated all residents repositioning scheo reduce the risk of fiverified there had m conducted to confir appropriate for R29 developed subsequ PU located on R29 Although the medic PU located on the a the initial measurer 0.5 cm unstageable dated 2/14/15, the fi individualized plan comprehensive assist interventions should to help decrease th additional pressure There was no indic consistently monito for the use of a boo her ankle and reduc had not routinely ap frequent removal of lacking to indicate i modified and re-eva approaches. In add applied a Mepilex fi instead of the phys Benzoin with a thick resulted in actual h R7 had a history of (Stage 2 and Stage developed a recurre	Il the risk factors. RN-B also are placed on a two hour dule when a PU is identified to urther development. RN-B not been a reassessment im the 2 hour schedule was o nor had a care plan been uent to the development of the 's ankle. ankle increased in size from ment (dated 1/6/15) of 0.5 cm x to a 1.0 cm x 1.0 cm PU facility failed to develop an of care based on a sessment to identify what d be implemented or modified e risk of R29 developing ulcers and promote healing. ation the pressure ulcer was red. Further R29 had an order of on her right foot to protect ce pressure. Because staff oplied the boot due to R29's f the boot, evidence was nterventions had been aluated for alternative dition, facility nursing staff oam dressing to the ankle ician ordered Tincture of k corn pad. This practice arm to R29. multiple pressure ulcers e 3) located on the coccyx, and ent coccyx ulcer on 2/7/15, sive reassessment and		4}				

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TATEMENT	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· · /		(X3) DA	). 0938-039 TE SURVEY MPLETED	
				NG		R	
		245274	B. WING _			/20/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
MAYO C	LINIC HEALTH SYST	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO I FAIRMONT, MN 56031	SOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
{F 314}	Continued From pa	age 12	{F 31	4}			
		r deterioration. Monitoring of ng .This practice resulted in					
	diagnoses listed or neurogenic bladder multiple sclerosis (	tted 5/20/13 and had in the care plan including: r, history of foot ulcer, stage 2, MS), history of low back tory of buttocks pressure ulcer e.					
	indicated R7 had a severe cognitive im indicated R7 requir staff with bed mobi chair, and assistan Documentation on	assessment dated 12/31/14, BIMS score of 6, indicating pairment. The MDS also red extensive assistance of two lity, transfers from bed and ce of two with toileting. the assessment identified that PU over a bony prominence.					
	dated 5/6/14, identi the right gluteal fold 0.6 cm. The stage through 7/21/14 to pressure ulcer. On	a Wound Tracking Form, ified R7 had a stage 2 PU on d region measuring 1.6 cm x 2 PU increased in size a 10 cm x 4 cm stage 2 7/25/14 Wound Tracking tion indicated R7 had the ulcers:					
	stage 2 PU left but (2) b. Wound #2: stage 3 PU (Full th Subcutaneous fat r tendon or muscle is buttocks.	0.1 cm x 0.1 cm open area tocks. 1.0 cm x 0.8 cm x 0.3 cm deep ickness tissue loss. nay be visible but bone, s not exposed) on right 3.0 cm x 2.0 cm stage 3 PU on					

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		AND HUMAN SERVICES				FORM	03/31/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245274	B. WING _				R 20/2015
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT			00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031	)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 314}	stage 2 PU on right (5) e. Wound #5: 3 stage 2 PU right bu (6) f. Wound #6: stage 2 PU right bu (7) g. Wound #7: 2 stage 2 PU right bu (7) g. Wound #7: 2 stage 2 PU right bu (7) g. Wound #7: 2 stage 2 PU right bu (7) 7/21/14- 4:39 p. -"Resident continue inner buttock area. bloody drainage no Documented. Will of 7/25/14- 2:26 p.m. assessment with ne and small open are dressing applied to open to air"; (3) 7/2 Note -Late entry 7:3 related to resident's areas with increase Aquacel and Mepile only applied to left f area." 10:00 a.m" right buttock dress larger Mepilex alon Will fax physician for Physical Therapy (F open areas and ne side. " The pressure were eventually hea Review of R7's meet Tracking Form date documentation that stage 2 PU. The for	<ul> <li>buttocks</li> <li>3.0 cm x 2.0 cm x 1.0 cm deep ttocks.</li> <li>1.0 cm x 0.2 cm x 0.1 cm deep ttocks.</li> <li>2.0 cm x 1.8 cm x 0.1 cm deep ttocks</li> <li>2.0 cm x 1.8 cm x 0.1 cm deep ttocks</li> <li>a were documented in progress</li> <li>m. Skin/Wound Note es with skin breakdown on (R) Measured at 10 x 4 cm with ted. Mepilex applied. continue to monitor"; (2) Skin/Wound Note- "Skin ew open areas on (R) buttock a on left buttock. Mepilex R buttock and left buttock 7/14- 5:03 p.m. Skin/Wound 30 a.m "Called into room s right buttock, noted pressure ed depth and red in color. ex dressings applied. Mepilex buttock stage 2 pressure '3 cm red drainage noted on ing, dressing changed and g with new Aquacel applied. or order to have wound care PT) to see. Family notified of ed for resident to lay down on e ulcers noted on the buttocks</li> </ul>	{F 31	4}			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED	
		245274	B. WING _		R 02/20/2015		
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	02/		
MAYO C	LINIC HEALTH SYSTI	EM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
{F 314}	identified the wound area with red drains. There was no furth Wound Tracking For staff had monitored whether it had imprimedical record lack the resident's skin is structures to deterr be applied to one and When interviewed of stated R7 was toile and after breakfast indicated that repose when she was toile aware that R7 had repositioned every When NA-B was in p.m. she stated R7 two staff (extensive stand lift to transfer was toileted before after lunch, and in the received reposition During observation at 5:57 a.m. R7 wa back (supine position position. At 6:19 a.1 assist R7 out of be joined to assist with use of an EZ stand completion of cares NA-C positioned R7 seated position and the lift swing to tran- bathroom. It was no relieving cushion in	d as a 0.8 cm x 2.5 cm open age and a pink wound bed. er documentation on any orms since 2/7/15 to indicate d the progress of the PU, roved and/or worsened. The ked any other assessment of integrity and supporting mine how long pressure could area without ill effect. on 2/19/15, at 1:24 p.m. NA-A ted in the a.m. after getting up then after lunch. NA-A further sitioning was provided for R7 ted. NA-A stated she was a PU and should be 2 hours. terviewed on 2/19/15, 2:26 required the assistance of e assist) and utilized the EZ r and toilet. NA-B stated R7 breakfast, after breakfast, the p.m. and stated R7	{F 31	4}			

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NC	APPROVE 0. 0938-039
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
			A. BOILDI			R
		245274	B. WING _			/20/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BO FAIRMONT, MN 56031	( 800	_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 314}	applied to the right a from the toilet. When area was painful R7 long but not right not The care plan revise identified a goal that further skin breakdo for PU developmen needs, bowel incom motion, pain and my care plan had not b current gluteal fold new individualized i During interview wit 2/20/15, at 8:10 a.m had not been revise current PU nor had reassessment beer risk factors other th dated 10/30/14, whi of 18, indicating mil The DON verified th the skin integrity an determine how long one area without ill to determine wheth schedule was effect promote skin integri verified the facility p residents when they schedule was define breakfast, after lund toileting/repositionin allow/provide for a c but had the potentiar	gluteal fold when assisted en questioned whether the 7 stated, "It hurts when I sit too ow". Sed/reviewed on 1/19/15, tt R7 would remain free of own and identified her at risk t related to medications, ADL tinence, decreased range of edical diagnosis. However, the een updated to include the PU and failed to identify any nterventions related to the PU. th the DON and RN-A on h. it was verified the care plan ed nor modified to include the a comprehensive n conducted related to R7's an the Braden assessment ich identified R7 with a score d risk for PU development. here was no assessment of d it's supporting structures to pressure could be applied to effect. The facility was unable er a 2 hour repositioning tive to maintain and/or ity for R7. However, the DON practice had been to reposition y were toileted. The toileting ed as: before and after ch and in the p.m. This	{F 31	4}		

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	<del>,                                    </del>				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
						F	R
		245274	B. WING			02/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER						
MAYO CI	LINIC HEALTH SYSTE	EM - FAIRMONT			800 MEDICAL CENTER DRIVE,PO BOX 800 FAIRMONT, MN 56031	) 	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	~	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIZ TAG		CROSS-REFERENCED TO THE APPROP		DATE
	t		<u></u>		DEFICIENCY)		
{F 314}	Continued From pa	000 16	( = 2.	4 41			
נדיס ין	again until after the	-	{F 31	14}			
	dyani unui anei ine						
		multiple pressure ulcers					
		cyx and recently developed					
		er on 2/7/15. The facility did vidualized plan of care based					
	on a comprehensiv	e reassessment to identify					
		should be implemented or					
		crease the risk of R7 al pressure ulcers and to					
		the ulcer located on the					
	coccyx. A lack of a	ssessment to determine					
		epositioning schedule was was not conducted and					
		evisions to the care plan were					
	not developed and	monitored to determine					
	effectiveness. This harm for R7.	practice resulted in actual					
		story of pressure ulcers,					
		ure ulcer on the left ankle on					
	not conducted nor v	hensive reassessment was					
		oped to promote healing and					
	prevent further dete	erioration. In addition, the					
		vide wound treatment per					
		d failed to conduct a physical luation as ordered by the					
	physician on 1/20/1						
		on 8/14/13, and had current the care plan that included:					
		nemic accident, hypertension,					
		t neoplasm and dementia.					
	The quarterly MDS	assessment dated 12/31/14,					
		severe cognition impairment					
	and required extens	sive assistance of staff with,					
	bed mobility, dressi	ing, transfers and mobility.					

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES					0938-0391	
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
_			A. BUILD	INC	G		R	
		245274	B. WING				ר 20/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	800 MEDICAL CENTER DRIVE, PO BOX 800	i		
MATOCI	LINIC HEALTH SYSTE			1	FAIRMONT, MN 56031			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION			
PRÉFIX			PREFI		(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	IAIE	BATE	
	1		<u> </u>	—				
(E 21/I)	Cartinued From no	47	(F. 0.)	- <i>1</i>				
{F 314}	Continued From pa	ge 17	{F 3 <sup>-</sup>	14	-}			
	D. J							
		9's medical record it was						
		cking Form had been initiated						
		dentified R19 as having an are ulcer located on the left						
		5 cm x 0.3 cm. The most						
		on on the Wound Tracking						
		14/15, which identified an						
		ure to the left ankle. No wound						
	<b>u</b> 1	e documented on 2/14/15.						
	A Braden Scale ass	sessment had been conducted						
	on 10/28/14 and ide	entified R19 as having a score						
		d risk for pressure ulcer						
		ollowing nursing progress						
	notes were docume							
		.m. "Resident noted with spa						
		rsing assistant) on the 6-2						
		d with open area on a heel						
		specified]. Resident noted with						
		s reported today from info						
	sheet received."							
		.m. "Resident noted with spa						
		the 6-2 shift. Resident noted						
	clipped only."	reported. Fingernails were						
		.m. "Resident had spa today.						
		s and weight obtained. Ears						
		washed. Does not shave.						
		nails checked not clipped.						
		on left ankle, dressed by						
	nurse."	· · · · · · · · · · · · · · · · · · ·						
	(4) 2/19/15- 11:15 a	a.m. "Round mepilex with						
		ed to left outer ankle to protect						
		kerlix. Left outer ankle has						
	been reddened with	ı 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.						

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		(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILUT		(V9) DA	MB NO. 0938-039 (X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         245274				) MULTIPLE CONSTRUCTION BUILDING		COMPLETED	
					R		
		B. WING		02/20/2015			
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
MAYO C	LINIC HEALTH SYSTE	EM - 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	D BE COMPLETION	
{F 314}	AG (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		{F 31	4}			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2015 APPROVED 0938-0391	
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			E SURVEY PLETED	
			A. BUILDING			R	
	245274		B. WING		02/20/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MAYO C	LINIC HEALTH SYSTE	EM - 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 314} F 520 SS=E	supporting structure pressure could be p effect. Further, the physician order to b a wound treatment evaluation had not y month later 2/20/15 R19 was identified y ulcers and develope region. The facility f factors after develop identify individualize staff to implement to breakdown. The tre ordered by the phys by physical therapy (1/20/15) had not ye that timely treatmer implemented. 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAN A facility must main assurance committe nursing services; a facility; and at least facility's staff. The quality assess committee meets a issues with respect and assurance actividevelops and imple	skin integrity and it's es to determine how long blaced on one area without ill DON stated R19 had a be seen by physical therapy for evaluation on 1/20/15 but the yet been completed (a full i). with a history of pressure ed a new PU on the left ankle failed to reassess R19's risk pment of the PU and failed to ed interventions necessary for o prevent further PU eatment utilized had not been sician and a wound evaluation ordered by the physician et been conducted for R19 so at could be developed and IBERS/MEET	{F 31			3/13/15	

Facility ID: 00359

If continuation sheet Page 20 of 23

		AND HUMAN SERVICES			FC	RM A	03/31/2015 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		245274	B. WING	i				
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE			
MAYO CI	LINIC HEALTH SYSTE	EM - FAIRMONT			00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	≣	(X5) COMPLETION DATE	
F 520	Continued From pa	ge 20	F	520				
	disclosure of the re except insofar as second compliance of such requirements of this Good faith attempts and correct quality a basis for sanction	s by the committee to identify deficiencies will not be used as is.						
	by: Based on observat review the facility fa appropriate plans o identified quality de ulcer assessment a revision/modificatio and prevention of p had the potential to	NT is not met as evidenced tion, interview and document ailed to develop and implement f actions to correct the ficiencies related to pressure and care plan n to promote proper healing ressure ulcers. This practice affect all residents in the essure ulcer development and			F520 A Lutz Wing QA meeting was held on March 11, 2015 to discuss survey findin from the surveys exited on December 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 plan action to correct the deficiencies identifi in the December 19, 2014 and Februar 20, 2015.	19, s of fied		
	assurance (QAA) c During review of the documentation it was survey results (exite communicated nor discussed by the m listed for pressure u note sheet there was identified the facility entry simply identifi	ed a quality assessment and ommittee meeting on 1/27/15. e QAA meeting minutes as noted that a review of the ed on 12/19/14) was not was any corrective action embers. In the note section ulcers on QAA communication ere two entries- (1) entry <i>v</i> talked about supplies and (2) ed "heel". The director of interviewed on 2/20/15, at			The Lutz Wing Director of Nursing and Lutz Wing Administrator will ensure Lut 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 meeting The DON and Administrator will conver	tz 5. A e js.		

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

Facility ID: 00359

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION		E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			PLETED	
		245274	B. WING			R 02/20/2015		
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/		
	LINIC HEALTH SYSTI	EM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
8: dd di qu re fu cc st Du cc de	survey results were documentation in the discussion related to quality of care prace recertification surves further stated she co conduct the skin ca stated in the approved DON could not prove communication relation	e QAA meeting and stated the e discussed. However, ne minutes lacked any to the identified deficient tices identified on the ey dated 12/19/14. The DON did not have enough time to are audits on the care plans as wed plan of correction. The vide any evidence that staff ated to the findings and actices had occurred since the	F 5	20	the QA committee more frequently quarterly as needed to respond to s results or other QA issues. The QA committee meeting agenda templa revised to include survey results as permanent meeting agenda item. Administrator will ensure that each committee meeting agenda include survey results and corrective action applicable, as a discussion topic. Completion Date: 3/13/15	survey te was a The QA s the		
	review the facility fa comprehensive rea ulcers were identifie monitored and prov healing and failed t prevent further dete of new pressure ulc R7 and R19) review pressure ulcers and	ion, interview and document ailed to conduct a assessment when pressure ed, failed to ensure staff vided care that promoted o develop measures to erioration and reduce the risk cers for 3 of 3 residents (R29, wed who had facility acquired d who all had a history of his caused actual harm for R29						
	developed an unsta on 1/6/15 which inc 1.0 cm by 2/14/15. treatment as ordere the fleece boot utili was a comprehens and subsequent int promote healing an	history of pressure ulcers, ageable ankle pressure ulcer creased in size from 0.5 cm to R29 did not receive the ed by the physician, nor was zed consistently to the foot nor ive reassessment conducted erventions developed to ad prevent further deterioration. ed in actual harm to R29.						

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

Facility ID: 00359

If continuation sheet Page 22 of 23

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391			
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245274	B. WING			R 02/20/2015				
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT			00 MEDICAL CENTER DRIVE, PO BOX 800 AIRMONT, MN 56031					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 520	Continued From pa	ige 22	F 5	520						
	(Stage 2 and Stage developed a recurre without a comprehe individualized interv condition of the ulco prevent further dete resulted in actual ha (3) R19, with a hist developed a pressu 1/20/15. A compre not conducted nor v interventions develop prevent further dete facility failed to prov physician order and therapy wound eval 1/20/15. F280 Based on observati review the facility failed to 3 of 3	tory of pressure ulcers, ure ulcer on the left ankle on hensive reassessment was								

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

Facility ID: 00359

If continuation sheet Page 23 of 23

PRINTED: 03/31/2015



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:

Mayo Clinic Health System - Fairmont March 18, 2015 Page 2

> Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 <u>Kathryn.serie@state.mn.us</u> 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 <u>Kathryn.serie@state.mn.us</u> Mayo Clinic Health System - Fairmont March 18, 2015 Page 3

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,

Kumala Fiske Downing

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

### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00359	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/20/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
M	AYO CLINIC HEALTH SYSTEM - FAIR	RMONT	800 MEDICAL CENTER DRIVE, FAIRMONT, MN 56031	PO BOX 800

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction           Completed           20565         01/28/2015	ID Prefix 2	Correction Completed 1390 01/28/2015	ID Prefix	Correction Completed 01/28/2015
	MN Rule 4658.0405 Subp.		NRule 4658.0800 Subp.		MN Rule 4658.0900 Subp.
LSC				LSC	
	Correction		Correction		Correction
ID Prefix	Completed	ID Prefix	Completed	ID Prefix	Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction		Correction		Correction
ID Prefix	Completed	ID Profix	Completed		Completed
- <i>"</i>		Б "	·		·
LSC		LSC		LSC	
	Correction		Correction		Correction
ID Prefix	Completed	ID Prefix	Completed	ID Prefix	Completed
Reg. #		Reg. #			
LSC				LSC	
	Correction		Correction		Correction
ID Profix	Completed	ID Prefix	Completed	ID Prefix	Completed
Reg. #					
		LSC		LSC	
Reviewed B	Reviewed By	Date:	Signature of Surveyor:		Date:
State Agend	×v KS/kfd	03/05/2015	5	28591	02/20/2015
Reviewed B CMS RO	Reviewed By	Date:	Signature of Surveyor:		Date:
Followup to	o Survey Completed on: 12/19/2014		Check for any Uncorrected Defi Uncorrected Deficiencies (CM		
STATE FOR	M: REVISIT REPORT (5/99)		Page 1 of 1		Event ID: QDJW12

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00359	B. WING		F <b>02/2</b>	₹ 0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTI		CAL CENTE T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of the the Minnesota Dep Determination of w corrected requires requirements of the number and MN Ru When a rule contai comply with any of	hether a violation has been				
	re-inspection with a result in the assess	any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota D	2/19/15 and 2/20/1 determined that the MN Rule 4658.052 corrected. This und effect and will be re	TS: visit was completed on 5. During this onsite visit it was following corrections order 5 Subp. 3. A. B. was NOT corrected order/s will remain in eviewed at the next onsite visit. rder/s will be reviewed for		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for N Homes.	oftware. to	
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

6899

If continuation sheet 1 of 24

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		00359	B. WING 02/2			
AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
	LINIC HEALTH SYSTI		NCAL CENTE	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLE DATE	
{2 000}	Continued From pa	age 1	{2 000}			
	200} 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.			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/ 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 whi are in violation of the state statute after statement, "This Rule is not met as evidenced by." Following the surveyor findings are the Suggested Method of Correction and the Time Period For Correction.	rule ch the	
				PLEASE DISREGARD THE HEADING 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 F VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		
2 255	MN Rule 4658.007 Assurance Commit	0 Quality Assessment and ttee	2 255		3/13/15	
	assessment and as of the administrator services, the medic designated by the r three other member representing discip	ust maintain a quality ssurance committee consisting r, the director of nursing cal director or other physician medical director, and at least ers of the nursing home's staff, lines directly involved in quality assessment and				

QDJW12

If continuation sheet 2 of 24

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		R <b>02/20/2015</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	LINIC HEALTH SYST			ER DRIVE, PO BOX 800		
			NT, MN 5603	PROVIDER'S PLAN OF CO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 255	Continued From pa	age 2	2 255			
	respect to which quarespect to which quarespropriate plans of quality deficiencies address, at a minimaddress, at a minimaddres	ent is not met as evidenced ion, interview and document ailed to develop and implemen of actions to correct the eficiencies related to pressure		corrected		
	assurance (QAA) of During review of the documentation it we survey results (exit communicated nor discussed by the me listed for pressure note sheet there we identified the facility entry simply identified nursing (DON) was 8:35 a.m. about the survey results were documentation in the	ted a quality assessment and committee meeting on 1/27/15. e QAA meeting minutes ras noted that a review of the ed on 12/19/14) was not was any corrective action nembers. In the note section ulcers on QAA communication ere two entries- (1) entry y talked about supplies and (2) ied "heel". The director of s interviewed on 2/20/15, at e QAA meeting and stated the e discussed. However, he minutes lacked any to the identified deficient				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00359	B. WING		R 02/20/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AYO CI	LINIC HEALTH SYST		NCAL CENTER NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 255	Continued From pa	age 3	2 255			
	recertification surve further stated she of conduct the skin ca stated in the appro DON could not pro communication rela	ctices identified on the ey dated 12/19/14. The DON did not have enough time to are audits on the care plans as wed plan of correction. The wide any evidence that staff ated to the findings and actices had occurred since the d 12/19/14.				
	Refer to 0900-Based on observation, intervie and document review the facility failed to cor a comprehensive reassessment when press 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 of new pressure ulcers for 3 of 3 residents (F R7 and R19) reviewed who had facility acqui pressure ulcers and who all had a history of pressure ulcers. This caused actual harm for R29, R7 and R19.	ew the facility failed to conduct eassessment when pressure ed, failed to ensure staff vided care that promoted to develop measures to erioration and reduce the risk cers for 3 of 3 residents (R29, wed who had facility acquired d who all had a history of				
	developed an unst on 1/6/15 which ind 1.0 cm by 2/14/15. treatment as order the fleece boot utili was a comprehens and subsequent in promote healing ar	a history of pressure ulcers, ageable ankle pressure ulcer creased in size from 0.5 cm to R29 did not receive the ed by the physician, nor was ized consistently to the foot nor sive reassessment conducted terventions developed to nd prevent further deterioration ted in actual harm to R29.				
	(Stage 2 and Stage developed a recurr without a compreh- individualized inter-	ry of multiple pressure ulcers e 3) located on the coccyx and rent coccyx ulcer on 2/7/15 ensive reassessment and ventions to monitor the er and promote healing and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00359	B. WING			R 02/20/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			20/2010	
		800 MEC		R DRIVE, PO BOX 800			
		FAIRMONT FAIRMO	NT, MN 56031				
X4) ID REFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 255	Continued From pa	ige 4	2 255				
	prevent further deter resulted in actual h	erioration. This practice arm for R7.					
	developed a pressi 1/20/15. A compre- not conducted nor interventions devel prevent further dete facility failed to pro- physician order and	tory of pressure ulcers, ure ulcer on the left ankle on hensive reassessment was were individualized oped to promote healing and erioration. In addition, the vide wound treatment per d failed to conduct a physical luation per physician order on					
	and document revia and update the car	ed on observation, interview ew the facility failed to revise e plan for 3 of 3 residents reviewed who had facility ulcers.					
	director of nursing communicate the fi QAA committee for ensure the resident are identified, asse subsequent individ developed on the p developed and we ensure the plan is i	THOD OF CORRECTION: The and administrator could ndings from the survey to the review and develop a plan to ts at risk for skin breakdown ssments conducted with ualized interventions lan of care. An audit could be ekly audits conducted to mplemented. The data could QAA committee to ensure e.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			3/13/15	

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		R 02/20/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A		STATE, ZIP CODE	• • •	
		800 MEC		ER DRIVE, PO BOX 800		
AYO CI	LINIC HEALTH SYST		NT, MN 5603	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 5	2 570			
	<ul> <li><sup>2</sup> 570 Continued From page 5</li> <li>Subp. 4. Revision. A comprehensive plan care must be reviewed and revised by an interdisciplinary team that includes the atter physician, a registered nurse with respons for the resident, and other appropriate staf disciplines as determined by the resident's and, to the extent practicable, with the participation of the resident, the resident's guardian or chosen representative at least quarterly and within seven days of the revi- the comprehensive resident assessment re by part 4658.0400, subpart 3, item B.</li> <li>This MN Requirement is not met as evide by: Based on observation, interview and document review the facility failed to revise and updated care plan for 3 of 3 residents (R29, R7 and</li> </ul>			corrected		
	Findings include:	facility acquired pressure				
	R29 was admitted diagnoses listed or fibrillation, cerebroy	on 12/11/12 and current In the care plan included: atrial vascular disease, peripheral PVD) and hypertension.				
	the director of nurs pressure ulcer (PU	05 p.m. R29 was identified by ing (DON) to have a stage 2 ) on the outside right ankle acquired (1/6/15)while at the				
	at 6:46 a.m. NA-A from behind R29's her in a right side ly	of morning cares on 2/20/15, removed a long body pillow back, which had maintained ying position. During the emoved R29's blanket from her				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 02/20/2015	
		00359	B. WING			
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S		•	
	HOWDER ON SOFTEIER			R DRIVE, PO BOX 800		
	LINIC HEALTH SYST		NT, MN 56031	-		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		COMPLET DATE
IAG			IAG	DEFICIENCY		
2 570	Continued From pa	age 6	2 570			
		-				
		right foot and ankle area was				
		gauze. There was no				
		boot when the covers were aff were questioned about the				
		t, NA-A pointed on top of				
		inet and the boot was on top of				
		stated R29 frequently kicked				
		also noted that R29's right				
		on the mattress of the bed				
	when in the right si					
		29's medical record it was				
		Tracking Form that R29 was				
		stageable pressure ulcer				
		t outer ankle which measured				
		ers (cm) on 1/6/15. The Wound				
		umentation identified the ankle	•			
		o increase in size (1.0 cm)				
		was identified as a stage 2 PL	J			
	when last documer	nted on 2/14/15.				
	The care plan date	d 1/20/15, identified that R29				
		related to needing staff				
		d mobility, weight loss and at				
		cers. Other risk factors				
	included: needs as	ssistance with all activities of				
	daily living (ADLs),	has cognitive impairment,				
	decreased commu	nication, intermittent pain,				
		ulcers, diagnosis and				
		incontinence. Interventions				
		re plan included: (1)				
		te nutritional intake; (2) offer				
		pplement) twice daily; (3)				
		early S&S (signs and				
		irritation and or breakdown; (4)	)			
		ress on her bed; and (5) a use				
		shion with soft backed				
	wheelchair. The ca					
		n 8/5/14 for PU risk and it at R29 had an active pressure				
	epartment of Health					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		00359	D. WING		02/	20/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
MAYO C	LINIC HEALTH SYSTI		NT, MN 56031	R DRIVE, PO BOX 800		
(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) COMPLET DATE
2 570	Continued From pa	age 7	2 570			
	plan related to an in schedule, the ident	were not evident on the care ndividualized repositioning ification of the type of or that utilized a boot on her				
	DON verified there update documented that any additional implemented since	on 2/19/15, at 1:02 p.m. the had not been a revision nor d on the care plan to identify interventions that had been the identification of the nd which had increased in				
	listed on the care p bladder, history of f sclerosis (MS), hist	0/13 and had active diagnoses lan which included: neurogenic foot ulcer, stage 2, multiple cory of low back pressure ulcer pressure ulcer, malaise and	C			
	Tracking Form date stage 2 PU. The for which identified the identified the wound open area with red bed. There was no of the Wound Track	dical record revealed a Wound ed 2/7/15 identified R7 with a prm lacked documentation e location of the PU but d size as a 0.8 cm x 2.5 cm drainage and a pink wound o further documentation on any king Forms since 2/7/14 to ss of the PU, whether it had presened.				
	at 5:57 a.m. R7 wa her back (supine po position. At 6:19 a.i assist R7 out of be to assist with the tra an EZ stand mecha	of resident cares on 2/20/15 s observed lying on her bed or osition) with the bed in the low m. NA-A entered room to d and at 6:21 a.m. NA-C joined ansfer from bed with the use o anical lift. After completion of NA-A and NA-C positioned	Ł			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:	·····		
		00359	B. WING			R <b>20/2015</b>
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AYO CI	LINIC HEALTH SYST		NCAL CENTER	R DRIVE, PO BOX 800		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
2 570	Continued From pa	age 8	2 570			
	attached the support transfer R7 from the When assisted from that R7 had a 4 x 4 gluteal fold. When was painful R7 state but not right now". R7's last revised ca identify the gluteal revise and modify a PU. This care plan remain free of furth identified her at rish to medications, AD decreased range of diagnosis. However	her bed in seated position and brt belt from the lift swing to be bed into the bathroom. In the toilet, it was observed dedessing applied to the right questioned whether the area ted, "It hurts when I sit too long are plan dated 1/19/15 failed to fold PU (2/8/15) and failed to any interventions related to the n identified that R7 would her skin breakdown and k for PU development related PL needs, bowel incontinence, f motion, pain and medical er, the care plan had not been ed to reflect the current status				
	2/20/15, at 8:10 a.r	th the DON and RN-A on n. it was verified the care plan ed and/or modified.				
	diagnoses listed or history of transisch	on 8/14/13 and had current the care plan which included: emic accident, hypertension, t neoplasm and dementia.				
	noted there was a 1/20/15 which iden measured 0.5 cm > ankle. The Wound	19's medical record it was Wound Tracking Form initiated tified an unstageable PU < 0.3 cm and located on the lef Tracking Form was last 14/15 which identified an the left ankle.				
		of a.m. cares on 2/20/15 at d NA-R assisted R19 out of				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00359	B. WING			R <b>20/2015</b>
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
MAYO C	LINIC HEALTH SYSTE		ICAL CENTER NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 570	bed with the use of R19 was noted to h when staff uncover was dependent of s transfer out of bed. R19's care plan ide related to needing a mobility and occasi Other risk factors fo included-needing a including bed mobil impairment, needin decreased commun pressure ulcer. The that R19 had a curr the left ankle (1/20/ revisions and modif the current PU. During interview wit 2/20/15, at 8:15 a.m physician order for dressing for the wo the care plan had m interventions to pro further skin breakd had the current treat care plan. SUGGESTED MET The director of nurs ensure the care plan resident condition of educate staff on the current care plan.	a EZ stand mechanical lift. have a boot on her left ankle ed her foot. NA-C stated R19 staff to turn and reposition and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00359	B. WING		02/20/20	)15
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
	LINIC HEALTH SYSTE		ICAL CENTE NT, MN 5603	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE CO	(X5) MPLET DATE
2 570	Continued From pa	ige 10	2 570			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
{2 900}	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	{2 900}		3/1	6/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: "Uncorrected based The original licensi	ent is not met as evidenced d on the following findings. ng order issued on 12/19/15 Penalty assessment		corrected		
	review, the facility f comprehensive rea ulcers were identifie monitored and prov healing, and failed prevent further dete	ion, interview and document ailed to conduct a issessment when pressure ed, failed to ensure staff vided care that promoted to develop measures to erioration and reduce the risk cers for 3 of 3 residents (R29,				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00359	B. WING			R 02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
	LINIC HEALTH SYSTI		ICAL CENTEF NT, MN 56031	R DRIVE, PO BOX 800			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{2 900}	Continued From pa	age 11	{2 900}				
	pressure ulcers, an	who had facility acquired nd who all had a history of nese deficient practices caused 9 and R7.					
	Findings include:						
	developed an unsta on 1/6/15 which inc 1.0 cm by 2/14/15. treatment as ordered the fleece boot utili was a comprehens and subsequent int promote healing an	story of pressure ulcers, ageable ankle pressure ulcer creased in size from 0.5 cm to R29 did not receive the ed by the physician, nor was zed consistently to the foot nor ive reassessment conducted terventions developed to ad prevent further deterioration. ted in actual harm to R29.					
	had current diagno which included: atri	to the facility on 12/11/12 and ses listed on the care plan ial fibrillation, cerebrovascular vascular disease and					
	(MDS) assessment required extensive with bed mobility, tr toileting. The Brief (BIMS) indicated R indicating mild cogr assessment further unstageable press outer ankle. During identified that R29	quarterly Minimum Data Set t dated 1/7/15, identified R29 assistance of one to two staff ransfer, mobility, dressing and Interview for Mental Status 29 had a score of 12, nitive impairment. The r identified that R29 had an ure ulcer (PU) on her right g record review it was had a history of pressure					
	thickness loss of de open ulcer with a re	ed a stage 2 PU (Partial ermis presenting as a shallow ed-pink wound bed without her middle coccyx region 1/14.					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00359	B. WING			R <b>02/20/2015</b>	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
MAYO CI	LINIC HEALTH SYSTI		NT, MN 56031	R DRIVE, PO BOX 800			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
{2 900}	Continued From pa	age 12	{2 900}				
	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						
	subsequently applie further documentat area in the medical unstageable PU loc was identified. During further med	and a Polymer dressing was ed to the area. There was no tion related to the red scabbed I record until 1/6/15, when the cated on the right outer ankle					
	identified with a una right outer ankle wh centimeters (cm) o the Wound Trackin continued to increa	ing Form that R29 was stageable PU located on the hich measured 0.5 x 0.5 n 1/6/15. Documentation on Ig Form identified the ankle PU ise in circumference size (1.0					
	2/14/15. A nursing timed 12:56 p.m. ic area on her right ar	mented as a stage 2 PU on progress note dated 2/14/15, lentified that R29 had an open nkle that appeared red and					
	ankle. The note do Mepilex dressing, c and wrapped with k	ured as a 1.0 cm open area on cumented that staff reapplied a doubled, with a cut open area kerlix and no further					
	determine risk for p	sessment (tool used to pressure ulcer development) 1/7/15, which identified that					
	R29 had a score of of developing press	f 17, indicating only a mild risk sure ulcers. However, the ked an assessment of the skin					
	integrity and it's sup	pporting structures to g pressure can be on one area					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED				
		00359	B. WING	B. WING		R <b>02/20/2015</b>				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, 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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE				
{2 900}	DON stated she did reassessment relat R29 and verified th documented on the additional intervent since the identificat ulcer/wound which When interviewed of nursing assistant (N in the a.m. after ge and then after lunch repositioned hersel unless she would re though the MDS ide assistance with bed When NA-B was qu p.m. NA-B stated F one to two staff (ex EZ stand lift at time needs. NA-B furthe toileted before brea lunch, then in the p repositioned when During observation at 6:46 a.m. NA-A r from behind R29's her in a right side ly	y on 02/19/15, at 1:02 p.m. the d not have a comprehensive ted to the PU/skin integrity for ere had not been any revision e care plan to identify that any ions had been implemented tion of the pressure had increased in size. on 2/19/15, at 1:24 p.m. NA)-A stated R29 was toileted tting up and after breakfast h. NA-A further stated R29 f so they did not reposition her equest the assistance even entified R29 required staff d mobility. uestioned on 2/19/15, at 2:26 R29 required the assistance of tensive assist) or utilized the es for transfer and toileting er stated R29 was routinely akfast, after breakfast, after .m. and stated that R29 was toileted. of morning cares on 2/20/15, removed a long body pillow back, which had maintained <i>y</i> ing position. During the		DEFICIENCY	)					
	foot region and the covered with gauze foot boot when the staff was questione boot, NA-A pointed cabinet and the boo	emoved R29's blanket from her right foot and ankle area was e. There was no evidence of a covers were removed. When ed about the location of the d on top of R29's clothing bt was located on the top of stated R29 frequently kicked								

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED			
		00359	B. WING	B. WING		R <b>02/20/2015</b>			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
{2 900}	Continued From pa	age 14	{2 900}						
ankl whe The was assi risk inclu daily decc histo occa iden enco 240 mor sym the of a whe R29 devo repo com of th	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.								
	was at risk for PU r assistance with beer risk for pressure ul- included: needs as daily living (ADLs), decreased commu- history of pressure occasional urinary identified on the ca encourage adequa 240 ml Ensure (sup monitor and treat e symptoms) of skin the use of air mattr of a wheelchair cus wheelchair. The ca R29 had a current developed related repositioning scheo comprehensive rea								
	registered nurse (F physician order for of sleep to prevent R29 had a physicia Tincture of Benzoir over the PU located However, RN-A sta foam dressing with	on 2/20/15, at 7:30 a.m. RN)-A stated R29 had a use of a fleece boot at hours pressure. RN-A further stated on order dated 1/8/15 for use of and a thick corn pad applied d on the right outer ankle area. the d staff utilized a Mepilex the center cut out and applied							
	changed as neede	ssing. The dressing was d and every 3 days. RN-A s no specific physician order							

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00359	B. WING	B. WING		R 02/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	LINIC HEALTH SYSTI		ICAL CENTER NT, MN 56031	DRIVE, PO BOX 800			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV	ON SHOULD BE	(X5) COMPLET	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE	
{2 900}	Continued From pa	age 15	{2 900}				
	for this particular treatment. RN-A verified she						
		te any comprehensive					
		r discovery of the PU nor were					
	2	rentions evident on the care					
		the charge nurse should have					
		lan to reflect the condition of ve assessed the wound so					
	that individualized interventions could be						
	developed and implemented.						
		on 2/20/15, at 7:40 a.m.					
		stated that upon discovery of					
		neasured and the family and					
		I-B indicated that a Wound					
	Tracking Form wou						
		PU would be documented in d the DON notified. RN-B					
		ot been a comprehensive					
		pleted related to all the risk					
		he only assessment conducted					
		sessment which did not					
		II the risk factors. RN-B stated					
	all residents are pla						
		dule when a PU is identified to					
		urther development. RN-B ot been a reassessment					
		m the 2 hour schedule was					
		) nor had a care plan been					
		uent to the development of the					
	PU located on R29						
		al record identified that R29's					
	PU located on the a	ankle increased in size from					
		ment (dated 1/6/15) of 0.5 cm >	(				
		e to a 1.0 cm x 1.0 cm PU					
	individualized plan	facility failed to develop an					
		sessment to identify what					
		d be implemented or modified					
		e risk of R29 developing					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		00359	B. WING		R 02/20/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
	LINIC HEALTH SYST		NCAL CENTER	DRIVE, PO BOX 800	
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION (X5
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE DAT
{2 900}	Continued From pa	age 16	{2 900}		
	consistently monitor for the use of a book her ankle and reduce had not routinely and frequent removal of lacking to indicate modified and re-ever approaches. The far dressing to the ank- ordered Tincture of This practice result R7 had a history of (Stage 2 and Stage developed a recurr without a compreh- individualized inter- and prevent further the ulcer was lacking actual harm for R7 R7, admitted 5/20/ care plan which inter- history of foot ulcer (MS), history of low of buttocks pressure The quarterly MDS identified R7 with and Status (BIMS) score cognitive impairmer indicated that R7 re- two staff with bed re- and chair and with	13 had diagnoses listed on the cluded: neurogenic bladder, r, stage 2, multiple sclerosis v back pressure ulcer, history re ulcer malaise and fatigue. a assessment dated 12/31/14 a Brief Interview for Mental re of 6 indicating severe ent. Documentation further equired extensive assistance o mobility, transfers from bed toileting. Documentation on so identified that R7 had stage			
		the medical record identified bry of multiple pressure ulcers.			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		R 02/20/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	LINIC HEALTH SYSTE	EM - EAIRMONT 800 MED	ICAL CENTER	DRIVE, PO BOX 800		
MATOC	LINIC HEALTH STST	FAIRMONT FAIRMOI	NT, 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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 900}	Continued From pa	ge 17	{2 900}			
	Tracking Form iden the right gluteal fold cm x 0.6 cm stage through 7/21/14 to pressure ulcer. On the following press the Wound Trackin (1) a. Wound 1- 0 stage 2 PU left butt (2) b. Wound 2- 1 stage 3 PU (Full thi Subcutaneous fat n tendon or muscle is buttocks. (3) c. Wound 3- 3. right buttocks. (4) d. Wound 4- 0 stage 2 PU on right (5) e. Wound 5- 3 stage 2 PU on right (5) e. Wound 5- 3 stage 2 PU right but (6) f. Wound 6- 1 stage 2 PU right but (7) g. Wound 7- 2 stage 2 PU right but (8) f. Wound 8- 1 stage 2 PU right	1 cm x 0.1 cm open area ocks. 0 cm x 0.8 cm x 0.3 cm deep ckness tissue loss. nay be visible but bone, s not exposed) on right 0 cm x 2.0 cm stage 3 PU on 5 cm x 0.5 cm x 0.1 cm deep buttocks 0 cm x 2.0 cm x 1.0 cm deep ttocks. 0 cm x 0.2 cm x 0.1 cm deep ttocks. 0 cm x 1.8 cm x 0.1 cm deep				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00359	B. WING			R <b>20/2015</b>
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
-		800 MEC		R DRIVE, PO BOX 800		
	LINIC HEALTH SYST		NT, MN 56031	-		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	HE APPROPRIATE	COMPLET DATE
{2 900}	Continued From pa	age 18	{2 900}			
	Aquacel and Mepile only applied to left 10:00 a.m 3 cm re buttock dressing, d Mepilex along with physician for order Therapy (PT) to se areas and need for The pressure ulcer eventually healed. Review of R7's me	ed depth and red in color. ex dressings applied. Mepilex buttock stage 2 pressure area. ed drainage noted on right fressing changed and larger new Aquacel applied. Will fax to have wound care Physical e. Family notified of open resident to lay down on side. is noted on the buttocks were dical record revealed the				
	documentation that stage 2 PU. The for which identified the identified the woun area with red drain. There was no furth Wound Tracking For staff had monitored	orm dated 2/7/15, had t R7 had developed a recurren orm lacked documentation e location of the PU but d as a 0.8 cm x 2.5 cm open age and a pink wound bed. her documentation on any orms since 2/7/15 to indicate d the progress of the PU, roved and/or worsened.	t			
	at 5:57 a.m. R7 wa her back (supine p position. At 6:19 a. assist R7 out of be to assist with the tr an EZ stand mecha cares, at 6:24 a.m. R7 on the edge of attached the support transfer from the be noted that R7 had a the seat of the whe R7 had a 4 x 4 drest	of resident cares on 2/20/15 as observed lying on her bed or osition) with the bed in the low m. NA-A entered room to d and at 6:21 a.m. NA-C joined ansfer from bed with the use o anical lift. After completion of NA-A and NA-C positioned her bed in seated position and ort belt on the lift swing to ed into the bathroom. It was a pressure relieving cushion in pelchair. It was observed that ssing applied to the right ssisted from the toilet. When	d f			

SUMMARY ST. CH DEFICIENC ULATORY OR I ned From pa "It hurts wh nterviewed R7 was toile er breakfas ed that repo he was toile hat R7 had oned every NA-B was ir	EM - FAIRMONT 800 MED FAIRMON ATEMENT OF DEFICIENCIES 'Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 19 en I sit too long but not right on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be	NT, MN 56031	TATE, ZIP CODE R DRIVE, PO BOX 800	CTION DULD BE	0/2015 (X5) COMPLET DATE
ALTH SYST SUMMARY ST. CH DEFICIENC ULATORY OR I ned From particulation of the thurts who nterviewed R7 was toile on breakfas and that repo he was toile hat R7 had oned every NA-B was ir	EM - FAIRMONT EM - FAIRMONT ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 19 een I sit too long but not right on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours. hterviewed on 2/19/15, 2:26	DDRESS, CITY, S DICAL CENTER NT, MN 56031 PREFIX TAG {2 900}	R DRIVE, PO BOX 800 I PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP	02/20	0/2015 (X5) COMPLET
ALTH SYST SUMMARY ST. CH DEFICIENC ULATORY OR I ned From particulation of the thurts who nterviewed R7 was toile on breakfas and that repo he was toile hat R7 had oned every NA-B was ir	EM - FAIRMONT 800 MED FAIRMON ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 19 en I sit too long but not right on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours.	ID PREFIX TAG {2 900}	R DRIVE, PO BOX 800 I PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP	OULD BE	COMPLET
SUMMARY ST. CH DEFICIENC ULATORY OR I ned From pa "It hurts wh nterviewed R7 was toile er breakfas ed that repo he was toile hat R7 had oned every NA-B was ir	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 19 en I sit too long but not right on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours. hterviewed on 2/19/15, 2:26	NT, MN 56031	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP	OULD BE	COMPLET
CH DEFICIENC ULATORY OR I red From particular "It hurts whether the second are breakfas and that report he was toile hat R7 had oned every NA-B was ir	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 19 een I sit too long but not right on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours. hterviewed on 2/19/15, 2:26	ID PREFIX TAG {2 900}	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF	OULD BE	COMPLET
uLATORY OR I led From pa "It hurts wh nterviewed R7 was toile or breakfas ed that repo he was toile hat R7 had oned every NA-B was ir	LSC IDENTIFYING INFORMATION) age 19 en I sit too long but not right on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours.	TAG {2 900}	CROSS-REFERENCED TO THE APPF		
"It hurts wh nterviewed R7 was toile er breakfas ed that repo he was toile hat R7 had oned every NA-B was ir	en I sit too long but not right on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours.				
nterviewed R7 was toile er breakfas ed that repo he was toile hat R7 had oned every NA-B was ir	on 2/19/15, at 1:24 p.m. NA-A eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours.				
R7 was toile er breakfas ed that repo he was toile hat R7 had oned every NA-B was ir	eted in the a.m. after getting up t then after lunch. NA-A further sitioning was provided for R7 eted. NA-A stated she was a PU and should be 2 hours.				
ff (extensive to transfe eted before nch, then in positioned v re plan revie d that R7 v eakdown ar oment relate ncontinence d medical of d not been fold PU and alized inter interview w , at 8:10 a.1 been revis PU nor had ssment bee tors other th 0/30/14, wh ndicating m	e assist) and utilized the EZ r and toilet. NA-B stated R7 e breakfast, after breakfast, the p.m. and further stated R7 when toileted. ised/reviewed on 1/19/15 vould remain free of further nd identified her at risk for PU ed to medications, ADL needs, e, decreased range of motion, diagnosis. However, the care updated to include the current d failed to identify any new ventions related to the PU. ith the DON and RN-A on m. it was verified the care plan ed nor modified to include the d a comprehensive n conducted related to R7's nan the Braden assessment nich identified R7 with a score ild risk for PU development. there was no assessment of				
	I not been old PU and alized inter- nterview wi at 8:10 a.r been revis PU nor had sment bee ors other th 0/30/14, wh dicating mi N verified t integrity ar ne how long	d not been updated to include the current old PU and failed to identify any new alized interventions related to the PU. Interview with the DON and RN-A on at 8:10 a.m. it was verified the care plan been revised nor modified to include the PU nor had a comprehensive sment been conducted related to R7's ors other than the Braden assessment D/30/14, which identified R7 with a score dicating mild risk for PU development. N verified there was no assessment of integrity and it's supporting structures to ne how long pressure can on one area II effect. The facility was unable to	d not been updated to include the current old PU and failed to identify any new alized interventions related to the PU. hterview with the DON and RN-A on at 8:10 a.m. it was verified the care plan been revised nor modified to include the PU nor had a comprehensive sment been conducted related to R7's ors other than the Braden assessment D/30/14, which identified R7 with a score dicating mild risk for PU development. N verified there was no assessment of integrity and it's supporting structures to he how long pressure can on one area II effect. The facility was unable to	a not been updated to include the current old PU and failed to identify any new alized interventions related to the PU. Interview with the DON and RN-A on at 8:10 a.m. it was verified the care plan been revised nor modified to include the PU nor had a comprehensive sment been conducted related to R7's ors other than the Braden assessment D/30/14, which identified R7 with a score dicating mild risk for PU development. N verified there was no assessment of integrity and it's supporting structures to ne how long pressure can on one area II effect. The facility was unable to ne whether a 2 hour repositioning	d not been updated to include the current old PU and failed to identify any new alized interventions related to the PU. Interview with the DON and RN-A on at 8:10 a.m. it was verified the care plan been revised nor modified to include the PU nor had a comprehensive sment been conducted related to R7's ors other than the Braden assessment D/30/14, which identified R7 with a score dicating mild risk for PU development. N verified there was no assessment of integrity and it's supporting structures to he how long pressure can on one area II effect. The facility was unable to

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00359		B. WING			R <b>20/2015</b>
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
MAYO C	LINIC HEALTH SYSTE		NT, MN 56031	DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 900}	promote skin integr had been to reposit toileted. The toiletii before and after bre p.m. This toileting/r allowed/provided for residents reposition hours (as residents breakfast and then lunch). R7 had a history of located on the cocce another coccyx ulce not develop an indir on a comprehensiv what interventions a modified to help de developing addition promote healing of coccyx. A lack of a whether a 2 hour re appropriate for R7 y modifications and r not developed and effectiveness. This harm for R7. R19, who had a his developed a pressu 1/20/15. A compre not conducted nor y interventions develop prevent further dete facility failed to prov physician order and	tive to maintain and/or ity for R7. Facility practice ion residents when they were ng schedule was defined as: eakfast, after lunch and then epositioning schedule had not ir a 2 hour schedule but had ned potentially between 3-4 toileted immediately after not again until after the noon multiple pressure ulcers eyx and recently developed er on 2/7/15. The facility did vidualized plan of care based e reassessment to identify should be implemented or crease the risk of R7 al pressure ulcers and to the ulcer located on the ssessment to determine epositioning schedule was was not conducted and evisions to the care plan were monitored to determine practice resulted in actual tory of pressure ulcers, are ulcer on the left ankle on hensive reassessment was were individualized oped to promote healing and erioration. In addition, the vide wound treatment per d failed to conduct a physical luation as ordered by the	{2 900}			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
	or connection		A. BUILDING:	<u> </u>		
	00359		B. WING			R 20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		800 MED		R DRIVE, PO BOX 800		
	LINIC HEALTH SYST		NT, MN 56031	-		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		COMPLET DATE
				DEFICIENCY	()	
{2 900}	Continued From pa	age 21	{2 900}			
	R19 was admitted	on 8/14/13, and had current				
		the care plan that included:				
		nemic accident, hypertension,				
		t neoplasm and dementia.				
	The quarterly MDS	assessment dated 12/31/14,				
		severe cognition impairment				
		sive assistance of staff with,				
	bed mobility, dress	ing, transfers and mobility.				
	During review of B	19's medical record it was				
		Wound Tracking Form initiated				
		dentified R19 with an				
	unstageable, 0.5 ci	m x 0.3 cm pressure ulcer				
		ankle. The most recent				
		this Wound Tracking Form was	3			
	pressure to the left	ch identified an unstageable				
		re documented on 2/14/15.				
		d lacked an assessment of the				
	skin integrity and it	's supporting structures to				
		g pressure can be on one area				
	without ill effect.					
		sessment was conducted on ified R19 with a score of 18,				
		sk for pressure ulcer				
		following nursing progress				
	notes were docume					
		o.m. Resident noted with spa				
		the 6-2 shift. Resident noted				
		a heel [which heel, is not				
		it noted with no other skin lay from info sheet received.				
		b.m. Resident noted with spa				
		the 6-2 shift. Resident noted				
		reported. Fingernails were				
	clipped only.					
		.m. Resident had spa today.				
		Is and weight obtained. Ears				
	epartment of Health	washed. Does not shave.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00050	B. WING		R	
	00359				02/	20/2015
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE <b>R DRIVE, PO BOX 800</b>		
IAYO CL	INIC HEALTH SYSTI		NT, MN 56031	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLET DATE
{2 900}	Continued From pa	age 22	{2 900}			
	Open area remains nurse. (4) 2/19/15- 11:15 a center cut out appli it and wrapped with been reddened with During observation at 7:30 a.m. NA-C a bed with the use of R19 was noted to h when staff uncover was dependent of s transfer from the be During observation 2/20/15 at 8:05 a.m present, a dime siz aspect of the left ar was dressed with a cut out and the dre The wound was red had drainage noted they were not sure with the center cut improve or worsen, and appeared red i R19's care plan ide ulcers related to ne with bed mobility ar incontinence. Othe breakdown include ADLs including bed impairment, needin decreased communi The care plan failed had a PU located of	of morning cares on 2/20/15 and NA-R assisted R19 out of a EZ stand mechanical lift. have a boot on her left ankle ed her foot. NA-C stated R19 staff to turn and reposition and ed of R19's left ankle wound on h. with the DON and RN-A ed open area on the outer hkle was noted. The wound hepilex dressing with center ssing was covered with gauze. ddened at the periphery and d. The DON and RN-A stated whether the Mepilex dressing out was making the wound They stated it looked worse	r			
	-	th the DON and RN-A on				
nesota De	epartment of Health					

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		DENTRION NONDER.	A. BUILDING:		R	
	00359		B. WING		02/20/2015	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	INIC HEALTH SYST		ICAL CENTEF NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI		
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE DATE	
{2 900}	Continued From pa	age 23	{2 900}			
	physician order for dressing for the wo had been no reass ulcer risk after deve (1/20/15) and verifi revised to reflect in and prevent further identified PU. Furt physician order to b a wound treatment evaluation had not later 2/20/15). R19 was identified ulcers and develop region. The facility factors after develop identify individualize staff to implement to breakdown. The tree ordered by the physical therapy (1/20/15) had not y	n. neither staff could locate a the use of the Mepilex bund. The DON verified there essment of R19 for pressure elopment of the pressure ulcer ed the care plan had not been terventions to promote healing r skin breakdown of the her, the DON stated R19 had a be seen by physical therapy for evaluation on 1/20/15 but the yet been completed (month with a history of pressure red a new PU on the left ankle failed to reassess R19's risk opment of the PU and failed to ed interventions necessary for to prevent further PU eatment utilized had not been sician and a wound evaluation r ordered by the physician et been conducted for R19 so nt was developed and	ı			
pesota De	epartment of Health					

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		DENTRION NONDER.	A. BUILDING:		R	
	00359		B. WING		02/20/2015	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IAYO CL	INIC HEALTH SYST		ICAL CENTEF NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI		
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE DATE	
{2 900}	Continued From pa	age 23	{2 900}			
	physician order for dressing for the wo had been no reass ulcer risk after deve (1/20/15) and verifi revised to reflect in and prevent further identified PU. Furt physician order to b a wound treatment evaluation had not later 2/20/15). R19 was identified ulcers and develop region. The facility factors after develop identify individualize staff to implement to breakdown. The tree ordered by the physical therapy (1/20/15) had not y	n. neither staff could locate a the use of the Mepilex bund. The DON verified there essment of R19 for pressure elopment of the pressure ulcer ed the care plan had not been terventions to promote healing r skin breakdown of the her, the DON stated R19 had a be seen by physical therapy for evaluation on 1/20/15 but the yet been completed (month with a history of pressure red a new PU on the left ankle failed to reassess R19's risk opment of the PU and failed to ed interventions necessary for to prevent further PU eatment utilized had not been sician and a wound evaluation r ordered by the physician et been conducted for R19 so nt was developed and	ı			
pesota De	epartment of Health					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00359	B. WING		02/20/20	15
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
	LINIC HEALTH SYSTE		ICAL CENTE NT, MN 5603	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE CO	(X5) MPLET DATE
2 570	Continued From pa	ige 10	2 570			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
{2 900}	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	{2 900}		3/10	6/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: "Uncorrected based The original licensi	ent is not met as evidenced d on the following findings. ng order issued on 12/19/15 Penalty assessment		corrected		
	review, the facility f comprehensive rea ulcers were identifie monitored and prov healing, and failed prevent further dete	ion, interview and document ailed to conduct a issessment when pressure ed, failed to ensure staff vided care that promoted to develop measures to erioration and reduce the risk cers for 3 of 3 residents (R29,				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00359		B. WING		R 02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	LINIC HEALTH SYSTI		ICAL CENTER	R DRIVE, PO BOX 800		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
{2 900}	Continued From pa	age 11	{2 900}			
	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:					
	developed an unsta on 1/6/15 which inc 1.0 cm by 2/14/15. treatment as ordered the fleece boot utili was a comprehens and subsequent int promote healing an	story of pressure ulcers, ageable ankle pressure ulcer creased in size from 0.5 cm to R29 did not receive the ed by the physician, nor was zed consistently to the foot nor ive reassessment conducted rerventions developed to ad prevent further deterioration red in actual harm to R29.				
	had current diagno which included: atri	to the facility on 12/11/12 and ses listed on the care plan ial fibrillation, cerebrovascular vascular disease and				
	(MDS) assessment required extensive with bed mobility, tr toileting. The Brief (BIMS) indicated R indicating mild cogr assessment further unstageable press outer ankle. During identified that R29	quarterly Minimum Data Set t dated 1/7/15, identified R29 assistance of one to two staff ransfer, mobility, dressing and Interview for Mental Status 29 had a score of 12, nitive impairment. The r identified that R29 had an ure ulcer (PU) on her right g record review it was had a history of pressure ad a stage 2 RU (Partial				
	thickness loss of de open ulcer with a re	ed a stage 2 PU (Partial ermis presenting as a shallow ed-pink wound bed without her middle coccyx region 1/14.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED				
	00359		B. WING			R <b>20/2015</b>			
					•				
	PROVIDER OR SUPPLIER		DDRESS, CITY, S						
MAYO CLINIC HEALTH SYSTEM - FAIRMONT 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031									
(X4) ID		ATEMENT OF DEFICIENCIES	ID		VIDER'S PLAN OF CORRECTION				
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		COMPLET DATE			
				DEFICIENCY	()				
{2 900}	Continued From pa	age 12	{2 900}						
[= 000]			(= 000)						
	$O_{22} = 0/10/15$ at 10.0	En m. D20 was identified by							
		05 p.m. R29 was identified by ing (DON) to have a stage 2							
		right ankle region which was							
		1/6/15) while at the facility.							
		, ,							
		gress notes were reviewed							
		12/4/14, identified that R29							
		on the right outer ankle and							
		0.5 cm scabbed area with							
		and a Polymer dressing was ed to the area. There was no							
		tion related to the red scabbed							
		I record until 1/6/15, when the							
		cated on the right outer ankle							
	was identified.	3							
	During further med	lical record review it was noted							
		ing Form that R29 was							
		stageable PU located on the							
		hich measured 0.5 x 0.5							
		n 1/6/15. Documentation on							
		g Form identified the ankle PU	)						
		use in circumference size (1.0 mented as a stage 2 PU on							
		progress note dated 2/14/15,							
		dentified that R29 had an open							
		nkle that appeared red and							
	swollen and measu	ured as a 1.0 cm open area on							
		cumented that staff reapplied a	a						
		doubled, with a cut open area							
		kerlix and no further							
	documentation sine								
		sessment (tool used to pressure ulcer development)							
		1/7/15, which identified that							
		f 17, indicating only a mild risk							
		sure ulcers. However, the							
		ked an assessment of the skin							
		pporting structures to							
		g pressure can be on one area				1			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	00359					R <b>20/2015</b>			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, S	TATE, ZIP CODE					
MAYO CLINIC HEALTH SYSTEM - FAIRMONT 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
{2 900}	DON stated she did reassessment relat R29 and verified th documented on the additional intervent since the identificat ulcer/wound which When interviewed of nursing assistant (N in the a.m. after ge and then after lunch repositioned hersel unless she would re though the MDS ide assistance with bed When NA-B was qu p.m. NA-B stated F one to two staff (ex EZ stand lift at time needs. NA-B furthe toileted before brea lunch, then in the p repositioned when During observation at 6:46 a.m. NA-A r from behind R29's her in a right side ly	a on 02/19/15, at 1:02 p.m. the d not have a comprehensive red to the PU/skin integrity for ere had not been any revision e care plan to identify that any ions had been implemented ion of the pressure had increased in size. On 2/19/15, at 1:24 p.m. NA)-A stated R29 was toileted tting up and after breakfast h. NA-A further stated R29 f so they did not reposition her equest the assistance even entified R29 required staff d mobility. Usestioned on 2/19/15, at 2:26 R29 required the assistance of tensive assist) or utilized the es for transfer and toileting or stated R29 was routinely akfast, after breakfast, after .m. and stated that R29 was toileted. of morning cares on 2/20/15, removed a long body pillow back, which had maintained <i>i</i> ing position. During the		DEFICIENC	7)				
	foot region and the covered with gauze foot boot when the staff was questione boot, NA-A pointed cabinet and the boo	moved R29's blanket from her right foot and ankle area was a. There was no evidence of a covers were removed. When ad about the location of the d on top of R29's clothing bt was located on the top of stated R29 frequently kicked							

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00359	B. WING	B. WING		R 02/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE			
MAYO CI	LINIC HEALTH SYST		ICAL CENTEF NT, MN 56031	R DRIVE, PO BOX 800			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{2 900}	Continued From pa	age 14	{2 900}				
	ankle was resting o	also noted that R29's right on the mattress of the bed the right side lying position.					
	was at risk for PU r assistance with beer risk for pressure ul- included: needs as daily living (ADLs), decreased commu- history of pressure occasional urinary identified on the ca encourage adequa 240 ml Ensure (sup monitor and treat e symptoms) of skin the use of air mattr of a wheelchair cus wheelchair. The ca R29 had a current developed related repositioning scheo comprehensive rea	assessment, the identification lized nor that a boot was					
	registered nurse (F physician order for of sleep to prevent R29 had a physicia Tincture of Benzoir over the PU located However, RN-A sta foam dressing with	on 2/20/15, at 7:30 a.m. RN)-A stated R29 had a use of a fleece boot at hours pressure. RN-A further stated on order dated 1/8/15 for use of and a thick corn pad applied d on the right outer ankle area. the d staff utilized a Mepilex the center cut out and applied					
	changed as neede	ssing. The dressing was d and every 3 days. RN-A s no specific physician order					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00359	B. WING			R <b>02/20/2015</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	LINIC HEALTH SYSTI		ICAL CENTER NT, MN 56031	DRIVE, PO BOX 800			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV	ON SHOULD BE	(X5) COMPLET	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE	
{2 900}	Continued From pa	age 15	{2 900}				
	for this particular tr	eatment. RN-A verified she					
		te any comprehensive					
		r discovery of the PU nor were					
	2	rentions evident on the care					
		the charge nurse should have					
		lan to reflect the condition of ve assessed the wound so					
		interventions could be					
	developed and imp						
		on 2/20/15, at 7:40 a.m.					
		stated that upon discovery of					
		neasured and the family and					
		I-B indicated that a Wound					
	Tracking Form wou						
		PU would be documented in d the DON notified. RN-B					
		ot been a comprehensive					
		pleted related to all the risk					
		he only assessment conducted					
		sessment which did not					
		II the risk factors. RN-B stated					
	all residents are pla						
		dule when a PU is identified to					
		urther development. RN-B ot been a reassessment					
		m the 2 hour schedule was					
		) nor had a care plan been					
		uent to the development of the					
	PU located on R29						
		al record identified that R29's					
	PU located on the a	ankle increased in size from					
		ment (dated 1/6/15) of 0.5 cm >	(				
		e to a 1.0 cm x 1.0 cm PU					
	individualized plan	facility failed to develop an					
		sessment to identify what					
		d be implemented or modified					
		e risk of R29 developing					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		00359	B. WING		R 02/20/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
	LINIC HEALTH SYST		NCAL CENTER	DRIVE, PO BOX 800	
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION (X5
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE DAT
{2 900}	Continued From pa	age 16	{2 900}		
	consistently monitor for the use of a book her ankle and reduce had not routinely and frequent removal of lacking to indicate modified and re-ever approaches. The far dressing to the ank- ordered Tincture of This practice result R7 had a history of (Stage 2 and Stage developed a recurr without a compreh- individualized inter- and prevent further the ulcer was lacking actual harm for R7 R7, admitted 5/20/ care plan which inter- history of foot ulcer (MS), history of low of buttocks pressure The quarterly MDS identified R7 with and Status (BIMS) score cognitive impairmer indicated that R7 re- two staff with bed re- and chair and with	13 had diagnoses listed on the cluded: neurogenic bladder, r, stage 2, multiple sclerosis v back pressure ulcer, history re ulcer malaise and fatigue. a assessment dated 12/31/14 a Brief Interview for Mental re of 6 indicating severe ent. Documentation further equired extensive assistance o mobility, transfers from bed toileting. Documentation on so identified that R7 had stage			
		the medical record identified bry of multiple pressure ulcers.			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		R <b>02/20/2015</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	LINIC HEALTH SYSTE	EM - EAIRMONT 800 MED	ICAL CENTER	DRIVE, PO BOX 800		
MATOC	LINIC HEALTH STST	FAIRMONT FAIRMOI	NT, 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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 900}	Continued From pa	ge 17	{2 900}			
	Tracking Form iden the right gluteal fold cm x 0.6 cm stage through 7/21/14 to pressure ulcer. On the following press the Wound Trackin (1) a. Wound 1- 0 stage 2 PU left butt (2) b. Wound 2- 1 stage 3 PU (Full thi Subcutaneous fat n tendon or muscle is buttocks. (3) c. Wound 3- 3. right buttocks. (4) d. Wound 4- 0 stage 2 PU on right (5) e. Wound 5- 3 stage 2 PU on right (5) e. Wound 5- 3 stage 2 PU right but (6) f. Wound 6- 1 stage 2 PU right but (7) g. Wound 7- 2 stage 2 PU right but (8) g. Wound 7- 2 stage 2 PU right	1 cm x 0.1 cm open area ocks. 0 cm x 0.8 cm x 0.3 cm deep ckness tissue loss. nay be visible but bone, s not exposed) on right 0 cm x 2.0 cm stage 3 PU on 5 cm x 0.5 cm x 0.1 cm deep buttocks 0 cm x 2.0 cm x 1.0 cm deep ttocks. 0 cm x 0.2 cm x 0.1 cm deep ttocks. 0 cm x 1.8 cm x 0.1 cm deep				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00359	B. WING			R <b>02/20/2015</b>	
	PROVIDER OR SUPPLIER	DR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
-		800 MEC		R DRIVE, PO BOX 800			
	LINIC HEALTH SYST		NT, MN 56031	-			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	HE APPROPRIATE	COMPLET DATE	
{2 900}	Continued From pa	age 18	{2 900}				
	Aquacel and Mepile only applied to left 10:00 a.m 3 cm re buttock dressing, d Mepilex along with physician for order Therapy (PT) to se areas and need for The pressure ulcer eventually healed. Review of R7's me	ed depth and red in color. ex dressings applied. Mepilex buttock stage 2 pressure area. ed drainage noted on right fressing changed and larger new Aquacel applied. Will fax to have wound care Physical e. Family notified of open resident to lay down on side. is noted on the buttocks were dical record revealed the					
	documentation that stage 2 PU. The for which identified the identified the woun area with red drain. There was no furth Wound Tracking For staff had monitored	orm dated 2/7/15, had t R7 had developed a recurren orm lacked documentation e location of the PU but d as a 0.8 cm x 2.5 cm open age and a pink wound bed. her documentation on any orms since 2/7/15 to indicate d the progress of the PU, roved and/or worsened.	t				
	at 5:57 a.m. R7 wa her back (supine p position. At 6:19 a. assist R7 out of be to assist with the tr an EZ stand mecha cares, at 6:24 a.m. R7 on the edge of attached the support transfer from the be noted that R7 had a the seat of the whe R7 had a 4 x 4 drest	of resident cares on 2/20/15 as observed lying on her bed or osition) with the bed in the low m. NA-A entered room to d and at 6:21 a.m. NA-C joined ansfer from bed with the use o anical lift. After completion of NA-A and NA-C positioned her bed in seated position and ort belt on the lift swing to ed into the bathroom. It was a pressure relieving cushion in pelchair. It was observed that ssing applied to the right ssisted from the toilet. When	d f				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		R 02/20/2015	
					UL/	20/2010
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	R DRIVE, PO BOX 800		
MAYO CI	LINIC HEALTH SYSTI		NT, MN 56031	-		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
{2 900}	Continued From pa	age 19	{2 900}			
	stated, "It hurts who now".	en I sit too long but not right				
	stated R7 was toile and after breakfast indicated that repose when she was toile	on 2/19/15, at 1:24 p.m. NA-A ted in the a.m. after getting up then after lunch. NA-A further sitioning was provided for R7 ted. NA-A stated she was a PU and should be 2 hours.				
	p.m. she stated R7 two staff (extensive stand lift to transfer was toileted before after lunch, then in was repositioned w The care plan revis identified that R7 w skin breakdown an development relate bowel incontinence pain and medical d plan had not been gluteal fold PU and individualized interv During interview wi 2/20/15, at 8:10 a.r had not been revise current PU nor had reassessment been risk factors other th dated 10/30/14, wh of 18, indicating mi	sed/reviewed on 1/19/15 rould remain free of further d identified her at risk for PU ed to medications, ADL needs, e, decreased range of motion, iagnosis. However, the care updated to include the current failed to identify any new ventions related to the PU. th the DON and RN-A on n. it was verified the care plan ed nor modified to include the				
	the skin integrity ar determine how long without ill effect. Th	a 2 hour repositioning				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		R 02/20/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
мауо с	LINIC HEALTH SYSTE		ICAL CENTER NT, MN 56031	DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 900}	promote skin integr had been to reposit toileted. The toiletii before and after bre p.m. This toileting/r allowed/provided for residents reposition hours (as residents breakfast and then lunch). R7 had a history of located on the cocce another coccyx ulce not develop an indir on a comprehensiv what interventions a modified to help de developing addition promote healing of coccyx. A lack of a whether a 2 hour re appropriate for R7 y modifications and r not developed and effectiveness. This harm for R7. R19, who had a his developed a pressu 1/20/15. A compre not conducted nor y interventions develop prevent further dete facility failed to prov physician order and	tive to maintain and/or rity for R7. Facility practice tion residents when they were ng schedule was defined as: eakfast, after lunch and then epositioning schedule had not or a 2 hour schedule but had ned potentially between 3-4 to toileted immediately after not again until after the noon multiple pressure ulcers cyx and recently developed er on 2/7/15. The facility did vidualized plan of care based e reassessment to identify should be implemented or crease the risk of R7 nal pressure ulcers and to the ulcer located on the assessment to determine epositioning schedule was was not conducted and evisions to the care plan were monitored to determine practice resulted in actual story of pressure ulcers, ure ulcer on the left ankle on hensive reassessment was were individualized oped to promote healing and erioration. In addition, the vide wound treatment per d failed to conduct a physical luation as ordered by the	{2 900}			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	of connection		A. BUILDING: _	·····		
		00359	B. WING		R 02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		SU ENDUONE 800 MED	ICAL CENTER	R DRIVE, PO BOX 800		
	LINIC HEALTH SYST	EM - FAIRMONT FAIRMO	NT, MN 56031			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH		COMPLET DATE
				DEFICIENCY	()	
{2 900}	Continued From pa	age 21	{2 900}			
	R19 was admitted	on 8/14/13, and had current				
		the care plan that included:				
		nemic accident, hypertension,				
		t neoplasm and dementia.				
	The quarterly MDS	assessment dated 12/31/14,				
		severe cognition impairment				
		sive assistance of staff with,				
		ing, transfers and mobility.				
		19's medical record it was				
		Wound Tracking Form initiated				
		dentified R19 with an m x 0.3 cm pressure ulcer				
		ankle. The most recent				
		this Wound Tracking Form was	3			
		ch identified an unstageable				
	pressure to the left					
		re documented on 2/14/15.				
		d lacked an assessment of the				
		's supporting structures to				
		g pressure can be on one area				
	without ill effect.	sessment was conducted on				
		ified R19 with a score of 18,				
		sk for pressure ulcer				
		following nursing progress				
	notes were docum					
		o.m. Resident noted with spa				
		the 6-2 shift. Resident noted				
		a heel [which heel, is not				
		It noted with no other skin				
		lay from info sheet received. .m. Resident noted with spa				
		the 6-2 shift. Resident noted				
		reported. Fingernails were				
	clipped only.	eponeal migorialo word				
		o.m. Resident had spa today.				
		Is and weight obtained. Ears				
	wachod Pari area	washed. Does not shave.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00050	B. WING		R	
		00359			02/	20/2015
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE <b>R DRIVE, PO BOX 800</b>		
IAYO CL	INIC HEALTH SYSTI		NT, MN 56031	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
{2 900}	Continued From pa	age 22	{2 900}			
	Open area remains nurse. (4) 2/19/15- 11:15 a center cut out appli it and wrapped with been reddened with During observation at 7:30 a.m. NA-C a bed with the use of R19 was noted to h when staff uncover was dependent of s transfer from the be During observation 2/20/15 at 8:05 a.m present, a dime siz aspect of the left ar was dressed with a cut out and the dre The wound was red had drainage noted they were not sure with the center cut improve or worsen, and appeared red i R19's care plan ide ulcers related to ne with bed mobility ar incontinence. Othe breakdown include ADLs including bed impairment, needin decreased communi The care plan failed had a PU located of	of morning cares on 2/20/15 and NA-R assisted R19 out of a EZ stand mechanical lift. have a boot on her left ankle ed her foot. NA-C stated R19 staff to turn and reposition and ed of R19's left ankle wound on h. with the DON and RN-A ed open area on the outer hkle was noted. The wound hepilex dressing with center ssing was covered with gauze. ddened at the periphery and d. The DON and RN-A stated whether the Mepilex dressing out was making the wound They stated it looked worse	r			
	-	th the DON and RN-A on				
nesota De	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OF CONTRECTION	IDENTIFICATION NOWIDEN.	A. BUILDING: _	·····	
		00359	B. WING		R <b>02/20/2015</b>
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
IAYO C	LINIC HEALTH SYST		NCAL CENTER NT, MN 56031	R DRIVE, PO BOX 800	
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE DATE
{2 900}	Continued From pa	age 23	{2 900}		
	physician order for dressing for the wo had been no reass ulcer risk after deve (1/20/15) and verifi revised to reflect in and prevent further identified PU. Furt physician order to b a wound treatment evaluation had not later 2/20/15). R19 was identified ulcers and develop region. The facility factors after develop identify individualize staff to implement to breakdown. The tree ordered by the physical therapy (1/20/15) had not y	n. neither staff could locate a the use of the Mepilex bund. The DON verified there essment of R19 for pressure elopment of the pressure ulcer ed the care plan had not been iterventions to promote healing r skin breakdown of the her, the DON stated R19 had a be seen by physical therapy for evaluation on 1/20/15 but the yet been completed (month with a history of pressure bed a new PU on the left ankle failed to reassess R19's risk opment of the PU and failed to ed interventions necessary for to prevent further PU eatment utilized had not been sician and a wound evaluation y ordered by the physician ret been conducted for R19 so nt was developed and	a r		

DEPARTMENT OF HEALT						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: QDJW
		TO BE COMP	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00359
1. MEDICARE/MEDICAID PROVID	DER NO.	3. NAME AND A (L3) MAYO CLI			I - FAIRMONT	4. TYPE OF ACTION: <u>2</u> (L8)
(L1) <b>245274</b> 2.STATE VENDOR OR MEDICAID	NO	(L4) 800 MEDIC				1. Initial 2. Recertification
(L2) <b>259845104</b>	NO.	(L4) 600 MEDIC		DRIVE, I	(L6) 56031	3. Termination 4. CHOW 5. Validation 6. Complaint
						7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
(L9)	10/2014 (124)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF		
<ol> <li>DATE OF SURVEY 12/</li> <li>ACCREDITATION STATUS:</li> </ol>	<b>19/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	00 FKIF 07 X-Ray	10 NF 11 ICF/II	14 CORF D 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC	(L10)	04 SNF	07 A-Ray 08 OPT/SP	12 RHC	16 HOSPICE	09/30
2 AOA 3 Other		01510	00 01 1.01	121010	in host fee	0,700
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY	Y IS CERTIFIED	AS:		
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			Requirements		2. Technical Personnel	6. Scope of Services Limit
			ce Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	<b>40</b> (L18)	I. A	Acceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	NF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	<b>40</b> (L17)	X B. Not in Cor	npliance with Prog	gram		
15. Total Certified Deas	40 (217)	Requirem	ents and/or Appli	ed Waivers	: * Code: <b>B</b>	(L12)
14. LTC CERTIFIED BED BREAKD	OWN	I			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
40						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
		,	01/10/0015			
<u>Kathy Hahn, HFE NE</u>	II		01/12/2015	(L19)	Kamala Fiske-Downing.	Enforcement Specialist 01/21/2015 (L20)
PA	RT II - TO BE	COMPLETED	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBI	ILITY	20. CON	APLIANCE WITH	I CIVIL	21 1 Statement of Fina	ncial Solvency (HCFA-2572)
			HTS ACT:		2. Ownership/Contro	ol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to					3. Both of the Above	e :
2. Facility is not Eligib	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREEN	IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNING		ENDING DA		VOLUNTARY _0	
04/01/1985	DEGININING	DALE	ENDING DA	IE	01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI	VESANCTIONS	(L23)		03-Risk of Involuntary Termination	on OTHER
25. LIC EXTENSION DATE.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	Tt. Suspension	r of 7 turnssions.	(L44)			00-Active
(L27)	B. Rescind St	spension Date:	. /			
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28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



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.

Mayo Clinic Health System - Fairmont January 2, 2015 Page 2

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 <u>Kathryn.serie@state.mn.us</u> 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

Mayo Clinic Health System - Fairmont January 2, 2015 Page 3

> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

Mayo Clinic Health System - Fairmont January 2, 2015 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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,

Kumalu 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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		TE SURVEY
		245274	B. WING		2/19/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	LINIC HEALTH SYSTE		1	800 MEDICAL CENTER DRIVE, PO BOX 800	
				FAIRMONT, MN 56031	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 000	INITIAL COMMEN	ſS	F 000		
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the form. Your electror be used as verificat				
F 248 SS=D	on-site revisit of you validate that substa		F 248	3	1/28/15
	of activities designed the comprehensive	ovide for an ongoing program ed to meet, in accordance with assessment, the interests and I, and psychosocial well-being			
	by: Based on observat review the facility fa activities for 1 of 3 activities.	NT is not met as evidenced ion, interview and document iled to provide ongoing residents (R3) reviewed for		1. The care plan goals and interventions for R3 were not changed, but the supporting documentation provided by th Activity Staff was noted to not be taking credit for visits that were either provided	
	seated in the dining himself during coffe observation on 12/	n 12/16/14, at 2:05 p.m. room asleep, at a table by e hour. During an l8/14, at 9:58 a.m. R3 was nair in the lounge area during a		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	

Electronically Signed

01/09/2015

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.

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
				IG			
		245274	B. WING _			19/2014	
	PROVIDER OR SUPPLIER	EM - FAIRMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 248	group activity of triv noted the R3 did no activity. Due to wea difficult to determine asleep. A subseque at 10:58 a.m. noted vocalizations/audibl Right" was playing of Audible sounds cor commercials and the 12/18/14, at 2:32 p. on his bed and ther playing on the radio R3's diagnosis iden minimum data set ( dementia. The brie (BIMS) was identified moderate cognitive identified that R3 w for locomotion. Dia plan dated 11/6/14, with hearing impair Review of the care identified the follow Focus: R3 is depent transportation to ac blindness. R3 also disruptive during ac what is going on. Goal: R3 will contrit 1:1 visits 2-3 x (time Interventions: Visit enjoys visiting abou Ensure KSMU is or	ia/newspaper reading. It was of participate with the group aring dark glasses, it was e whether R3 was awake or ent observation on 12/18/14, that R3 was making le sounds while the "Price is on the TV in the lobby. thinued throughout both the ne program. Observation on m. noted that R3 was asleep e was no evidence of music o while he was in his room. tified on the quarterly MDS) dated 10/22/14, was of interview for mental status ed as 9 which indicated impairment. The MDS further as totally dependent on staff ignoses identified in the care noted R3 as legally blind and ment. plan for R3 dated 11/6/14, ing: dent on staff to provide tivities r/t [related to] has hearing loss. R3 is often ctivities r/t not understanding	F 24	<ul> <li>visitors.</li> <li>2. There are currently selisted as having care plan as an intervention. The areviewing each plan for eappropriate frequency of retraining for capturing c whether provided by staft charted.</li> <li>3. We will continue to foll process. Through assess determine each resident interests, a care plan will with appropriate goals ar for achieving the goals. measurement of the effet those interventions will b minimum of a quarterly b revisions to the care plan needed.</li> <li>4. The Activity Director a will remain responsible for this process is carried ou updating the care plan. Director will monitor the of visits and other supportint documentation/charting f and report results at the Assurance meeting.</li> </ul>	ns with 1:1 visits activity director is effectiveness and visit. Also, the redit for visits, f or visitors will be low the RAI asment to 's individual be developed nd interventions Periodic ectiveness of e completed on a basis with n completed as nd her delegates or ensuring that ut, including The Activity charting for 1:1 ng for one quarter		

If continuation sheet Page 2 of 13

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	IG	` '	MPLETED
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	LINIC HEALTH SYST	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BOX FAIRMONT, MN 56031	300	
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F 248	Continued From pa	age 2	F 24	48		
	months of Novemb revealed that 1:1 s twice (2 x) in Nove lacking to indicate had occurred in De participation record that music from the R3's room on 12/18					
	1:52 p.m. verified t assisted R3 to grou added that R3 had	3's spouse on 12/18/2014, at hat activity staff invited and up activities. She further participated on rare occasions y just slept thru the group				
F 279 SS=D	at 2:37 p.m. verifie 1:1 staff/R3 visits of November 2014 ar had been provided		F 27	79		1/28/15
		the results of the assessment and revise the resident's in of care.				
	plan for each resid objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial htified in the comprehensive				
		t describe the services that are attain or maintain the resident's				

If continuation sheet Page 3 of 13

D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СОМ	PLETED
		245274	B. WING		12/19/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYST	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BOX 80 FAIRMONT, MN 56031	600	
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F 279	highest practicable psychosocial well-l §483.25; and any s be required under due to the resident §483.10, including under §483.10(b)(4 This REQUIREME by: Based on interview facility failed to cor plan, which include pressure ulcer was (R20) in the closed Findings include: R20 was admitted admission minimus 8/25/14 identified F pressure ulcers an one pressure ulcer further indicated R assistance with po positioning program Review of the wee dated 9/6/14 indica stage two pressure width by 0.1 cm de	<ul> <li>a physical, mental, and being as required under services that would otherwise §483.25 but are not provided is exercise of rights under the right to refuse treatment 4).</li> <li>NT is not met as evidenced w and document review the nplete a comprehensive care ed interventions, after a sidentified for 1 of 1 residents d record sample.</li> <li>on 8/18/14. Review of the m data set (MDS) dated R20 as being at risk for d currently having two stage is on the spine. The MDS 20 required physical sitioning, but did not have a</li> </ul>	F 27	<ul> <li>9</li> <li>1. R20 expired at the facility on 9/22/2014. It was noted in the pronotes that her condition rapidly de during the 35-days that she was a resident which may contribute to the observations reported in the Sum Deficiencies related to the skin conditions.</li> <li>2. There are no other residents id at this time with pressure ulcers.</li> <li>3. We will continue to follow the R Orders for Wound Care which are by the resident's physician at adm These orders state that "physiciar order alternative treatments as appropriate. MD must be notified new wounds, significant changes, non-healing wounds." The routine address skin tears, pressure ulce (Stages I-IV), and infected wound will also continue to apply interver prevent reoccurrence.</li> </ul>	colined he mary of ndition. entified outine e signed ission. hs may for all and e orders rs s. We	
	(R20) in the closed Findings include: R20 was admitted admission minimul 8/25/14 identified F pressure ulcers an one pressure ulcer further indicated R assistance with po positioning program Review of the wee dated 9/6/14 indica stage two pressure measured 2.2 cent width by 0.1 cm de pressure ulcer rem The stage one pre measured 1.0 cm I stage one pressure	d record sample. on 8/18/14. Review of the m data set (MDS) dated R20 as being at risk for d currently having two stage rs on the spine. The MDS 20 required physical sitioning, but did not have a m. kly wound measurement form ated R20 was identified with a e ulcer on the coccyx that timeters (cm) length by 1.8 cm opth. Measurements of the		<ul> <li>resident which may contribute to the observations reported in the Sum Deficiencies related to the skin contribute to the skin contribute to the skin contribute to the skin contribute to the skin contend of the skin co</li></ul>	he mary of ndition. entified outine e signed ission. as may for all and e orders rs s. We stions to r for are plan	

Facility ID: 00359

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COM	PLETED
		245274	B. WING		12/ <sup>-</sup>	19/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 279	Continued From pa	ace 4	F 279			
	unchanged on 9/21	-	1 270	that the implementation of those		
	Deview of D20le el	in concompant with the most		interventions is carried out and	itorod	
		in assessment with the most 14 indicated the resident had		documented. The plan will be mor for one quarter and results reported		
		nclude interventions of a every repositioning program.		next Quality Assurance meeting.		
	R20 was admitted ther back and had r breakdown. The carequiring assistance Interventions include cushions, monitor a encourage adequa plan did not address a positioning progr	ded; use of bed and wheelchair and treat breakdown and te nutritional intake. The care as nor include interventions of ram to prevent further				
	pressure ulcer to the identified on 9/6/14					
F 282 SS=D	12/19/14, at 1:00 p R20 did not include included in the skin skin breakdown no pressure ulcer to th	RVICES BY QUALIFIED	F 282			1/28/15
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of				
	This REQUIREME	NT is not met as evidenced				

If continuation sheet Page 5 of 13

	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	MB NO. 0938 (X3) DATE SURV COMPLETED	ΕY
		BERTHIOMONINGER.	A. BUILDING	G		
		245274			12/19/20	14
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	_	
MAYO C	LINIC HEALTH SYSTI	EM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031			
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F 282	Continued From pa	ae 5	F 282	2		
	Based on observar review the facility fa according to the pla (R3) reviewed for a Findings include: R3 had diagnoses set (MDS) dated 10 dementia, legally bl R3 was not provide care dated 11/6/14, Focus: R3 is deper transportation to ac blindness. R3 also disruptive during ac what is going on. Goal: R3 will contril 1:1 staff visits 2-3 x Interventions: Visit enjoys visiting about Ensure KSMU is or	tion, interview and document ailed provide activities an of care for 1 of 3 residents activities. on the quarterly minimum data 0/22/14, which included lind and hearing impairment. ed activities per the plan of which identified the following: adent on staff to provide ctivities r/t [related to] has hearing loss. R3 is often ctivities r/t not understanding bute to conversations during		<ol> <li>The care plan goals and interver for R3 were not changed, but the supporting documentation provided Activity Staff was noted to not be ta credit for visits that were either pro by staff or by his wife. Retraining of activity staff will be provided to mor accurately capture the data to supp interventions that are in place to er R3's well-being. The existing docu for charting these types of visits ha existing line to note when a resider visitors.</li> <li>There are currently seven (7) re- listed as having care plans with 1:1 as an intervention. The activity dir reviewing each plan for effectivened appropriate frequency of visit. Also retraining for capturing credit for vi whether provided by staff or visitor charted.</li> <li>We will continue to follow the R4 process. Through assessment to</li> </ol>	d by the aking vided of the re bort the ahance iment is an at has sidents visits ector is ess and b, the sits, s will be	
	seated in the dining himself during coffe observation on 12/' seated in a wheelcl group activity of triv noted the R3 did no activity. Due to we difficult to determin asleep. A subsequ at 10:58 a.m. notec vocalizations/audib Right" was playing	on 12/16/14, at 2:05 p.m. g room asleep, at a table by ee hour. During an 18/14, at 9:58 a.m. R3 was hair in the lounge area during a via/newspaper reading. It was of participate with the group aring dark glasses, it was e whether R3 was awake or ent observation on 12/18/14, d that R3 was making le sounds while the "Price is on the TV in the lobby. htinued throughout both the		<ul> <li>determine each resident's individual interests, a care plan will be developed with appropriate goals and interver for achieving the goals. Periodic measurement of the effectiveness those interventions will be completed minimum of a quarterly basis with revisions to the care plan completed needed.</li> <li>4. The Activity Director and her del will remain responsible for ensuring this process is carried out, includin updating the care plan. The Activity</li> </ul>	oped ntions of ed on a ed as egates g that g	

Facility ID: 00359

If continuation sheet Page 6 of 13

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		245274				
	PROVIDER OR SUPPLIER	245274	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	12	/19/2014
	LINIC HEALTH SYST	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BOX 8 FAIRMONT, MN 56031	00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 282	<ul> <li><sup>5</sup> 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.</li> <li>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.</li> <li>An interview with R3's spouse on 12/18/2014, at 1:52 p.m. verified that activity staff invited and</li> </ul>		F 28	Director will monitor the charting visits and other supporting documentation/charting for one q and report results at the next Qua Assurance meeting.	uarter	
F 314 SS=D	added that R3 had but more frequently activity. An interview with th 12/18/14, at 2:37 p conducted 1:1 staff November and no been provided in D verified the plan of written. 483.25(c) TREATM PREVENT/HEAL F Based on the comp resident, the facility who enters the faci	up activities. She further participated on rare occasions y just slept thru the group ne activity director (AD) on o.m. verified that activity staff f visits with R3 only 2 times in 1:1 visits by activity staff had ecember 2014. The AD care had not been followed as NENT/SVCS TO PRESSURE SORES orehensive assessment of a y must ensure that a resident lity without pressure sores pressure sores unless the	F 31	4		1/28/15

Facility ID: 00359

If continuation sheet Page 7 of 13

		AND HUMAN SERVICES			FORM	01/14/201 APPROVEI 0938-039
TATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245274	B. WING _		12/*	19/2014
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BOX 80 FAIRMONT, MN 56031	0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 314	individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores This REQUIREMEN by: Based on interview facility failed to imply prevent further skin residents (R20) rev sample and identifie Findings include: R20 was admitted of admission minimum 8/25/14 identified R pressure ulcers and one pressure ulcers further indicated R2 assistance with pos positioning program Review of the week dated 9/6/14 indicate stage two pressure measured 2.2 centi width by 0.1 cm dep pressure ulcer rema The stage one pressure measured 1.0 cm les stage one pressure measured 1.8 cm les	condition demonstrates that able; and a resident having eives necessary treatment and a healing, prevent infection and from developing. NT is not met as evidenced a and document review the lement interventions to a breakdown for 1 of 2 iewed in the closed record ed with pressure ulcers. on 8/18/14. Review of the n data set (MDS) dated 20 as being at risk for d currently having two stage is on the spine. The MDS 20 required physical sitioning, but did not have a n. Aly wound measurement form ted R20 was identified with a ulcer on the coccyx that meters (cm) length by 1.8 cm oth. Measurements of the ained unchanged on 9/21/14. seure ulcer to the right spine ength by 1.0 cm width. The e ulcer to the left spine ength by 1.8 cm width. he pressure ulcers remained	F 31	<ol> <li>R20 expired at the facility on 9/22/2014. It was noted in the pro notes that her condition rapidly ded during the 35-days that she was a resident which may contribute to th observations reported in the Summ Deficiencies related to the skin con</li> <li>There are no other residents ide at this time with pressure ulcers.</li> <li>We will continue to follow the Re Orders for Wound Care which are by the resident's physician at admit These orders state that "physician order alternative treatments as appropriate. MD must be notified new wounds, significant changes, non-healing wounds." The routine address skin tears, pressure ulcer (Stages I-IV), and infected wounds will also continue to apply interven prevent reoccurrence.</li> <li>The Director of Nursing and her delegates will remain responsible tensuring that a comprehensive ca includes a description of interventi that the implementation of those interventions is carried out and</li> </ol>	clined ne nary of ndition. entified outine signed ssion. s may for all and orders s s. We tions to	

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If continuation sheet Page 8 of 13

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTR	RUCTION		0938-039 E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COM	PLETED
		245274	B. WING			12/	19/2014
NAME OF	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYST	EM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTAND OF CORRECTIVE ACTION SHOUDSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	Review of the the s current date of 9/8/ one pressure ulcer was at risk for furth assessment further that included a eve repositioning progra- identify the new pre- Review of the most R20 was admitted her back and had r breakdown. The car requiring assistance Interventions include cushions, monitor a encourage adequa plan did not address positioning program the pressure ulcer Interview with regis 12/19/14, at 1:00 p R20 did not include included in the skin	kin assessment with the most (14, indicated R20 had a stage to the right and left spine and her skin breakdown. The r included interventions for R20 ry two hour turning and am. The assessment did not essure ulcer to the coccyx. t current care plan, indicated with two pressure ulcers on isk factors for further skin are plan identified R20 as e with positioning. ded; use of bed and wheelchair and treat skin breakdown and te nutritional intake. The care as nor include interventions of a n nor did the care plan identify to the coccyx area. stered nurse (RN)-B on .m. confirmed the care plan for assessment to prevent further r did it identify the new	F 3	docum for one	hented. The plan will be m e quarter and results repor Quality Assurance meeting.	ted at the	
F 441 SS=D	SPREAD, LINENS The facility must es Infection Control P	N CONTROL, PREVENT stablish and maintain an rogram designed to provide a comfortable environment and	F 4	41			1/28/15

Facility ID: 00359

If continuation sheet Page 9 of 13

		AND HUMAN SERVICES				FORM	01/14/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245274	B. WING			12/1	9/2014
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO CI	INIC HEALTH SYSTE	EM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ige 9	F4	41			
	Program under whi (1) Investigates, co in the facility; (2) Decides what prishould be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re- prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is inco professional practic (c) Linens Personnel must has transport linens so infection.	Atablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. The control Program esident needs isolation to of infection, the facility must to rohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted the context of the spread of					
	by: Based on observat failed to ensure sta gloves after remova incontinent product	NT is not met as evidenced tion and interview the facility ff washed hands and changed al of a urine soaked and prior to the provision of resident (R11) observed			A meeting for all nursing personnel scheduled for January 23, 2015. Th agenda will include a review of Infer Control, including the proper way to and doff gloves and hand washing,	he ction don	

Facility ID: 00359

If continuation sheet Page 10 of 13

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED
		245274		_			
		245274	B. WING _		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	19/2014
	PROVIDER OR SUPPLIER L <b>INIC HEALTH SYSTI</b>	EM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 3 FAIRMONT, MN 56031			800	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 441	Continued From pa	•	F 44	1			
	during morning car Findings include:	es.			and after providing personal cares. Personnel who do not attend the me will meet individually with the Directo Nursing.		
	nursing assistant (I gloves prior to was hands. NA-B proce face and legs while NA-B then assisted sitting position on the applied a gait belt the into the bathroom we use of a walker. R1 position in front of the and handled the vis brief. NA-B then ple plastic lined trash. toilet and without cle his neck, head, arm moistened washclo NA-B collected R11 stand and applied of NA-B then applied hands and assisted Without a change of following cares for brushed the dentur R11 for placement, electric razor and fit to the face and neo gloves after remova- incontinent brief an oral/denture care.	on 12/19/14, at 7:58 a.m. NA)-B was noted to donn hing and drying R11's face and eeded to apply lotion to R11's resident was lying in bed. I R11 to transfer from a lying to he edge of the bed and then o R11's waist. R11 ambulated with NA-B's assistance and the 1 remained in a standing the toilet while NA-B removed sibly urine soaked disposable aced the folded brief into the After R11 was seated on the hanging gloves, NA-B washed ns and back area with a th. It was observed that I's toiletries from the bed side deodorant to R11's underarms. lotion to R11's back, arms and d with dressing his upper body. of gloves, NA-B completed the R11: retrieved a denture cup, es, handed the dentures to shaved his facial hair using an nally applied after shave lotion ck area. NA-B did not change al of a urine soaked d prior to assistance with			The Director of Nursing (DON) and I delegates will continue to be respon for ensuring proper infection control practices, especially as they relate to preventing the spread of potential illu- through the misuse of protective equipment (e.g. gloves) and imprope handwashing. The Infection Control Specialist on campus may be consu as needed for assistance with provid re-education and audits of the systel 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 next three months and share her find at the next Quality Assurance meetin	sible o ness er I lited ding m at c, br the ding	
	8:32 a.m. she verifi urine soaked when	with NA-B on 12/19/14, at red the disposable brief was removed from R11 and unable to recall whether she					

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If continuation sheet Page 11 of 13

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
				G	
	PROVIDER OR SUPPLIER	245274	D. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	2/19/2014
	LINIC HEALTH SYSTE	EM - FAIRMONT		800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 466 4 SS=C V	changed her gloves during morning card During interview on director of nursing ( expected NA-B to v after providing care of gloves after cont incontinent product 483.70(h)(1) PROC WATER AVAILABIL The facility must es	and/or washed her hands es for R11. (2/19/14, at 10:30 a.m. the (DON) stated she would have vash her hands before and s and would expect a change act with a soiled/urine soaked EDURES TO ENSURE ITY tablish procedures to ensure ble to essential areas when	F 44		1/28/15
	by: Based on interview facility failed to ens water needs for the planned for, should occur. This had the residents residing i Findings include: The facility's emerg dated 1/24/14 was not specify a metho non-potable water of the gallons of water	ency water supply procedure reviewed. The procedure did od for distributing potable/ or calculations for estimating required daily to meet the nts and staff should there be a		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 Administrato 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	le re

Facility ID: 00359

If continuation sheet Page 12 of 13

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245274			12	/19/2014
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CC		/19/2014
	LINIC HEALTH SYST		800 MEDICAL CENTER DRIVE, PO FAIRMONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 466	During interview or facility environment the facility had a ver Trucking of Manka The environmental provide the date of and/or the amount case of water loss manager also conf arrangement for di	age 12 n 12/19/14 at 11:00 a.m. the tal service manager indicated erbal agreement with Viessen to MN, for non-potable water. I manager was unable to the arrangements/agreement that would be distributed in the The environmental service irmed there was no stributing/calculating potable or if needed in an emergency	F 46	6 water needs, etc. A review of information will be presented Quality Assurance meeting.		

Facility ID: 00359

If continuation sheet Page 13 of 13

DEPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES FS	274	0243	FORM	: 12/22/2014 APPROVED ). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1. /	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245274		B. WING		12/1	7/2014
	ROVIDER OR SUPPLIER	TEM - FAIRMONT	800 ME		ITATE, ZIP CODE NTER DRIVE. PO BOX 800 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	Minnesota Departm Fire Marshal Division the time of this surv	Survey was conduct tient of Public Safety, on, on December 17, rey, Mayo Clinic Hea	, State 2014. At Ith				£
	compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	as found to be in sub e requirements for pa id at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc fety Code (LSC), Ch e Occupancies.	articipation art 2000 ciation				
	constructed as follo The original building one-story, has a pa sprinkler protected Type I(332) constru The 1990 building A partial basement, is	g was constructed in rtial basement, is full and was determined	1972, is ly fire to be of has a rotected				
	detection in the corr corridors which is m department notificat	e alarm system with ridors and spaces op nonitored for automa tion. The facility has and had a census o	en to the tic fire a		(w)		
		٣		5			.5
LABORATO	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	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.



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Mayo Clinic Health System - Fairmont January 2, 2015 Page 2

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,

Kumalu 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

Minneso	ta Department of He	ealth			1 OI W	///////////////////////////////////////
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:	·	COIVIE	LETED
		00050	B. WING		40/4	0/004 4
		00359	D. WING		12/1	9/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTI		T, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correputsuant to a surver found that the defice herein are not corrected shall with a schedule of the the Minnesota Dep Determination of w corrected requires requirements of the number and MN Re When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota D	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
	epartment of Health / DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

(X6) DATE

01/09/15

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00359		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00359	B. WING		12/1	9/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
IAYO C	LINIC HEALTH SYSTE		NCAL CENTE	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure prot completion date, th corrected prior to e Minnesota Departm On December 16, surveyors of this De above provider and orders are issued. electronic plan of cor reviewed these ord they will be complet Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follor are the Suggested Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 17, 18, and 19th 2014, epartment's staff, visited the the following correction Please indicate in your orrection that you have ers, and identify the date wher ted. nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE		The assigned tag number far left column entitled "ID The state statute/rule num corresponding text of the s out of compliance is listed "Summary Statement of D column and replaces the " portion of the correction or column also includes the are in violation of the state statement, "This Rule is no evidenced by." Following findings are the Suggested Correction and the Time P Correction. PLEASE DISREGARD TH THE FOURTH COLUMN V STATES, "PROVIDER'S P CORRECTION." THIS API FEDERAL DEFICIENCIES WILL APPEAR ON EACH THERE IS NO REQUIREN SUBMIT A PLAN OF COR VIOLATIONS OF MINNES STATUTES/RULES.	Prefix Tag." ber and the tate statute/rule in the eficiencies" To Comply" der. This findings which statute after the ot met as the surveyors d Method of eriod For E HEADING OF VHICH LAN OF PLIES TO 5 ONLY. THIS PAGE. MENT TO RECTION FOR	

Minnesota Department of Health           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00359	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE		ICAL CENTE NT, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents		2 560			1/23/15
	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).					
	by: Based on interview facility failed to com plan, which include	and document review the plete a comprehensive care d interventions, after a identified for 1 of 1 residents record sample.		corrected		
	Findings include:					
	admission minimun 8/25/14 identified R pressure ulcers and one pressure ulcers further indicated R2	sitioning, but did not have a				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 4 00359			CONSTRUCTION		E SURVEY PLETED	
		B. WING				
				12/	19/2014	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE DRIVE, PO BOX 800		
MAYO C	LINIC HEALTH SYSTE		NT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLET DATE
2 560	Continued From pa	ige 3	2 560			
	dated 9/6/14 indica stage two pressure measured 2.2 centi width by 0.1 cm dep pressure ulcer rem. The stage one press measured 1.0 cm le stage one pressure measured 1.8 cm le Measurements of th unchanged on 9/21 Review of R20's sk current date of 9/8/ been assessed to in 2 hour turning and Review of the most R20 was admitted y her back and had re breakdown. The ca requiring assistance Interventions inclue cushions, monitor a encourage adequate plan did not address a positioning progr breakdown nor did pressure ulcer to the identified on 9/6/14 Interview with regis 12/19/14, at 1:00 p. R20 did not include included in the skin	in assessment with the most 14 indicated the resident had nclude interventions of a every repositioning program. current care plan, indicated with two pressure ulcers on isk factors for further skin re plan identified R20 as e with positioning. led; use of bed and wheelchair and treat breakdown and te nutritional intake. The care s nor include interventions of am to prevent further the care plan identify the ne coccyx area that had been tered nurse (RN)-B on .m. confirmed the care plan for interventions that were assessment to prevent further r did it identify the new				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00359	B. WING		12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	LINIC HEALTH SYSTI		ICAL CENTE NT, MN 5603	R DRIVE, PO BOX 800 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION A CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 560	Continued From pa	ige 4	2 560			
2 565	The director of nurs develop, review, an procedures to ensu- plans according to needs. The director of nurs educate all appropri- procedures. The dir designee could development ensure ongoing con TIME PERIOD FOR (21) days.	THOD OF CORRECTION: sing (DON) or designee could id/or revise policies and the residents individualized sing (DON) or designee could riate staff on the policies and ector of nursing (DON) or velop monitoring systems to mpliance. R CORRECTION: Twenty-one 5 Subp. 3 Comprehensive	2 565			1/23/15
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview and document ailed provide activities an of care for 1 of 3 residents ctivities.		corrected		
	Findings include:					
	set (MDS) dated 10 dementia, legally bl R3 was not provide	on the quarterly minimum data )/22/14, which included lind and hearing impairment. d activities per the plan of , which identified the following:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00359	B. WING		12/	12/19/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IAYO CI	LINIC HEALTH SYST		NCAL CENTER NT, MN 56031	DRIVE, PO BOX 800			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
2 565	Continued From pa	age 5	2 565				
	transportation to au blindness. R3 also disruptive during a what is going on. Goal: R3 will contri 1:1 staff visits 2-3 : Interventions: Visi enjoys visiting abo Ensure KSMU is o	ndent on staff to provide ctivities r/t [related to] b has hearing loss. R3 is often ctivities r/t not understanding bute to conversations during k (times) weekly. t in room 2-3x weekly. R3 ut farming and the "old days." n in his room as resident ore than music on TV per his					
	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.						
	months of Novemb revealed that 1:1 s twice in the month was no documenta December 2014 w activity staff had be	vity participation record for the ber and December 2014 taff visits were provided only of November 2014 and there ation for the month of hich indicated 1:1 visits by been provided as defined in the activity participation record also					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00359	B. WING		12/	12/19/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
	INIC HEALTH SYST		DICAL CENTER NT, MN 56031	R DRIVE, PO BOX 800			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 6	2 565				
		ion that music had been lio while R3 was in the room					
	1:52 p.m. verified to assisted R3 to grou added that R3 had	3's spouse on 12/18/2014, at hat activity staff invited and up activities. She further participated on rare occasions y just slept thru the group	\$				
	12/18/14, at 2:37 p conducted 1:1 in ro in November and n been provided in D	ne activity director (AD) on b.m. verified that activity staff bom visits with R3 only 2 times to 1:1 visits by activity staff had ecember 2014. The AD care had not been followed as	Ł				
	The activity directo importance of the i assessed residents	THOD OF CORRECTION: r could educate staff on the mplementation of 1:1 visits for s. The activity director could entation and report to the committee.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/23/15	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the nursing care plan which	r				
	A. a resident wh	o enters the nursing home					

STATE FORM

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED <b>12/19/2014</b>	
		00359	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
мауо с	LINIC HEALTH SYSTE	-M - FAIRMONT	NCAL CENTE NT, MN 5603	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 900	without pressure s pressure sores unle condition demonstr authenticates, that B. a resident w receives necessary promote healing, pu new sores from dev This MN Requirement by: Based on interview facility failed to imp prevent further skin residents (R20) rev sample and identified Findings include: R20 was admitted of admission minimum 8/25/14 identified R pressure ulcers and one pressure ulcer and further indicated R2 assistance with pos positioning program Review of the week dated 9/6/14 indica stage two pressure measured 2.2 centi width by 0.1 cm dep pressure ulcer remains The stage one pressure	ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and tho has pressure sores y treatment and services to revent infection, and prevent veloping. ent is not met as evidenced and document review the lement interventions to breakdown for 1 of 2 iewed in the closed record ed with pressure ulcers. on 8/18/14. Review of the n data set (MDS) dated 20 as being at risk for d currently having two stage s on the spine. The MDS 20 required physical sitioning, but did not have a	2 900	corrected		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00359	B. WING		12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	LINIC HEALTH SYSTE	-M - FAIRMONI	ICAL CENTER NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page 8 Measurements of the pressure ulcers remained unchanged on 9/21/14.		2 900			
	current date of 9/8/ one pressure ulcer was at risk for furth assessment further that included a ever repositioning progra identify the new pre- Review of the most R20 was admitted y her back and had ri breakdown. The ca requiring assistance Interventions includ cushions, monitor a encourage adequat plan did not addres	led; use of bed and wheelchair and treat skin breakdown and te nutritional intake. The care s nor include interventions of a n nor did the care plan identify				
	12/19/14, at 1:00 p. R20 did not include included in the skin	tered nurse (RN)-B on m. confirmed the care plan for interventions that were assessment to prevent further r did it identify the new he coccyx.				
	The administrator of current policy and pand could provide eulors. The administration	THOD OF CORRECTION: or designee could review the procedures on pressure ulcers, education to staff on pressure strator or designee could for compliance for treatment ressure ulcers.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		00359	B. WING		12/19/2014		
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		800 MED		R DRIVE, PO BOX 800			
IAYO CI	LINIC HEALTH SYST	EM - FAIRMONT FAIRMO	NT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLE DATE	
2 900	Continued From pa	age 9	2 900				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			1/23/15	
	control program m procedures which A. surveillance collection to identif residents; B. a system fo control of outbreak C. isolation an reduce risk of trans D. in-service e prevention and cor E. a resident h immunization prog defined in part 468 procedures of resid the prevention and F. the develop employee health p practices, including defined in part 465 G. a system for H. a system for products which affed disinfectants, antis incontinence produ I. methods for current standards of This MN Requirem by: Based on observat	ealth program including an ram, a tuberculosis program as 58.0810, and policies and dent care practices to assist in treatment of infections; ment and implementation of olicies and infection control g a tuberculosis program as 8.0815; or reviewing antibiotic use; or review and evaluation of ect infection control, such as eptics, gloves, and	5	corrected			

	T OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00359	B. WING		12/	19/2014
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	INIC HEALTH SYSTI	FM - FAIRMONT	ICAL CENTER NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 10	21390			
	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:					
	nursing assistant (I gloves prior to was hands. NA-B proce face and legs while NA-B then assisted sitting position on the applied a gait belt the into the bathroom we use of a walker. R1 position in front of the and handled the vise brief. NA-B then ple plastic lined trash. toilet and without cle his neck, head, arm moistened washcle NA-B collected R11 stand and applied of NA-B then applied hands and assisted Without a change of following cares for brushed the dentur R11 for placement, electric razor and fit to the face and neo gloves after removal	on 12/19/14, at 7:58 a.m. NA)-B was noted to donn hing and drying R11's face and eeded to apply lotion to R11's e resident was lying in bed. d R11 to transfer from a lying to he edge of the bed and then o R11's waist. R11 ambulated with NA-B's assistance and the 11 remained in a standing the toilet while NA-B removed sibly urine soaked disposable laced the folded brief into the After R11 was seated on the hanging gloves, NA-B washed ns and back area with a oth. It was observed that I's toiletries from the bed side deodorant to R11's underarms. Iotion to R11's back, arms and d with dressing his upper body of gloves, NA-B completed the R11: retrieved a denture cup, res, handed the dentures to shaved his facial hair using ar inally applied after shave lotion ck area. NA-B did not change al of a urine soaked id prior to assistance with				
		/ with NA-B on 12/19/14, at ied the disposable brief was				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 12/19/2014	
		00359	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	LINIC HEALTH SYSTI	-M - FAIRMONT	NCAL CENTER NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21390	Continued From pa	age 11	21390	DEFICIENCY	r)	
21000	urine soaked when indicated she was	removed from R11 and unable to recall whether she s and/or washed her hands	2.000			
	director of nursing expected NA-B to v after providing care	a 12/19/14, at 10:30 a.m. the (DON) stated she would have wash her hands before and es and would expect a change fact with a soiled/urine soaked				
	facility failed to ens (nursing assistant ( result fo Mycobacter resident contact pe	and document review the ure that 1 of 5 nursing staff (NA)-C) had a negative test erium tuberculosis prior to ar facility policy. This had the II 34 residents residing in the				
	Findings include:					
	(TST) records it wa hired on 03/30/14. dated 3/10/14 india the US in Kenya ar past 2 years. NA-C was terminated on noted that NA-C wa blood assey mycob test was completed indicated that NA-C	nployee tuberculin skin test is noted that NA-C was initially A tuberculin screening tool cated NA-C was born outside ind had visited Kenya in the did not report to work and 4/25/14. On 8/3/14, it was as rehired by the facility. A pacterium tuberculosis (BAMT) d on 8/4/14 and the result C had a positive (+) tuberculin entation was lacking to				
	indicate that NA-C private physician of department for follo per facility policy. A local public health	had been referred to either his r the local public health ow-up and potential treatment letter from the physician or department attesting to the ire of the applicant must be				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00359	B. WING	B. WING		12/19/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
MAYO C	LINIC HEALTH SYSTE	-M - FAIRMONI	ICAL CENTER NT, MN 56031	R DRIVE, PO BOX 800			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	ge 12	21390				
		te of hire according to facility vas not available for review.					
	with the director of that she would expe- documentation of a beginning orientation contact with resident that NA-C was an of have a regular sche with the DON indict unit with resident co shifts): 8/25/14, 8/2 9/14/14, 9/15/14, 9/ indicated she was of positive result from Review of the facilit Control Plan with a indicated: The org enforce the latest re centers for disease regarding prevention of tuberculosis (TB	30 a.m. during an interview nursing (DON) it was verified ect an employee to have negative TST prior to on on the unit and having nts. The DON further verified on-call employee and did not edule. Review of the timecard red NA-C had worked on the ontact on the following dates (8 26/14, 8/27/14, 9/1/14, 1/16/14 and 9/26/14. The DON unaware that NA-C had a the BAMT blood test. ty policy titled, Tuberculosis n approved date of 11/18/14 panization has adopted and will ecommendations of the control and prevention (CDC) on of occupational transmissior ) among its employees;					
	Screening: 1.) All offered a position w presence of infection the tuberculin skin or blood assay for r (BAMT) (e.g. Quan	e Employees (on hire) individuals that have been vill be screened for the on with m. tuberculosis using test (TST) for baseline testing mycobacterium tuberculosis tiFeron). 2.) TB screening					
	condition of employ utilized, a two-step implemented. 4.) TST(>10 mm) or B their private physici	AMT will be referred either to an or the local public health ow-up and potential treatment.					

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		00359	B. WING	. WING		12/19/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE			
MAYO CI			NCAL CENTER NT, MN 56031	R DRIVE, PO BOX 800			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From pa	age 13	21390				
		ng to the non-infectious nature ist be received prior to date of					
	The administrator of policies to ensure p procedures were for The director of nurs staff on infection co of nursing could me director of nursing screening requirem new employees pri An audit could be of reported to the qua	THOD OF CORRECTION: could review and revise proper infection control ollowed during resident cares. sing could educate nursing ontrol procedures. The director onitor staff compliance. The could ensure the proper nents have been completed for or to contact with residents. developed and the results ality assurance committee. R CORRECTION: Twenty-one					
21435	MN Rule 4658.090 Recreation Program	0 Subp. 1 Activity and m; General	21435			1/23/15	
	home must provide recreation program based on each indi strengths, and nee meet the physical, well-being of each comprehensive res comprehensive pla 4658.0400 and 46 provided opportuni	al requirements. A nursing e an organized activity and h. The program must be ividual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the sident assessment and an of care required in parts 58.0405. Residents must be ties to participate in the lopment of the activity and h.					
	This MN Requirem	ent is not met as evidenced					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MAYO CI	INIC HEALTH SYSTI	EM - FAIRMONT	DICAL CENTE NT, MN 5603	ER DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 14	21435			
	review the facility fa	ion, interview and document ailed to provide ongoing residents (R3) reviewed for		corrected		
	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 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.					
	minimum data set of dementia. The brie (BIMS) was identifi moderate cognitive identified that R3 w for locomotion. Dia plan dated 11/6/14, with hearing impair					
	identified the follow	plan for R3 dated 11/6/14, /ing: ndent on staff to provide				

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00359	B. WING		12/	19/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	LINIC HEALTH SYST		NCAL CENTER NT, MN 56031	R DRIVE, PO BOX 800		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21435	Continued From pa	age 15	21435			
	blindness. R3 also disruptive during ac what is going on. Goal: R3 will contri 1:1 visits 2-3 x (tim Interventions: Visit enjoys visiting abou Ensure KSMU is on	ctivities r/t [related to] b has hearing loss. R3 is often ctivities r/t not understanding bute to conversations during es) weekly. t in room 2-3 x weekly. R3 ut farming and the "old days." n in his room as resident ore than music on TV per his				
	months of Novemb revealed that 1:1 st twice (2 x) in Nove lacking to indicate had occured in Dec participation record	ity participation record for the ber and December 2014 taff visits were provided only mber and documentation was that any activity staff 1:1 visits cember 2014. The activity d also lacked documentation e radio had been provided in 8/14.				
	1:52 p.m. verified to assisted R3 to grou added that R3 had	3's spouse on 12/18/2014, at hat activity staff invited and up activities. She further participated on rare occasions y just slept thru the group	5			
	at 2:37 p.m. verifie 1:1 staff/R3 visits o November 2014 ar	ne activity director on 12/18/14 ad that activity staff conducted only twice the month of nd no 1:1 visits by activity staff yet in December 2014.	,			
	The activity directo review/revise policy staff regarding resi	THOD FOR CORRECTION: r and/or designee could y and provide education for dent activities. The Quality ssurance (QAA) committee				

Minnesota Department of Health         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00359         NAME OF PROVIDER OR SUPPLIER       STREET AU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/19/2014	
				800 MET		DRIVE, PO BOX 800
	LINIC HEALTH SYST	EM - FAIRMONT FAIRMO	NT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE COMPLET HE APPROPRIATE DATE	
21435	Continued From page 16		21435			
	could do random audits to ensure compliance.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days		e			