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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VG2D
Facility ID: 00770

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245218**

2. STATE VENDOR OR MEDICAID NO. (L2) **715522100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAYO CLINIC HEALTH SYSTEM - LAKE CITY**
(L4) **500 WEST GRANT STREET**
(L5) **LAKE CITY, MN** (L6) **55041**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/21/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Justin Main, HFE NE II 7/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 7/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/20/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245218

July 19, 2016

Mr. Jacob Suckow, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Dear Mr. Suckow:

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 June 15, 2016 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

An equal opportunity employer.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 19, 2016

Mr. Jacob Suckow, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: Project Number S5218025

Dear Mr. Suckow:

On June 1, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 6, 2016. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 1, 2016.

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 1, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on April 1, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on . The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections were required.

On June 21, 2016, 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 May 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 15, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 21, 2016, as of June 15, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 15, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 1, 2016. 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 July 1, 2016, 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 July 1, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 1, 2016, is to be rescinded.

In our letter of June 1, 2016, 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 July 1, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 15, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 1, 2016

Ms. Erin Hilligan, , Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: Project Number S5218025

Dear Ms. Hilligan:

On April 13, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 1, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 17, 2016, the Minnesota Department of Health and on May 4, 2016, the Minnesota Department of Public Safety 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 April 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2016. 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 April 1, 2016. The deficiencies not corrected are as follows:

280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being

The most serious deficiencies in your facility were found to be 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.

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 June 6, 2016. (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 July 1, 2016. (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 July 1, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2016. 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 - Lake City is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective July 1, 2016. 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 action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board’s Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to: Tamika.Brown@cms.hhs.gov.

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later

than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown by phone at (312)353-1502 or by email at Tamika.Brown@cms.hhs.gov.

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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 October 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245218 (Y1)	A. Building B. Wing (Y2)	6/21/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 06/15/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 7/19/2016	SIGNATURE OF SURVEYOR 35990	DATE 6/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

July 19, 2016

Ms. Erin Hilligan, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: Project Number S5218025

Dear Mr. Suckow:

A Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility on June 21, 2016 and imposed a daily fine in the amount of $750.00.

On June 21, 2016, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on June 21, 2016 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is $750.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $307.00, 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 $1057.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

Sincerely,

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

cc: Program Assurance Unit
Penalty Assessment Deposit Staff

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00770 (Y1)	A. Building B. Wing (Y2)	6/21/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 06/15/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 06/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GN/kfd	DATE 7/19/2016	SIGNATURE OF SURVEYOR 35990	DATE 6/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VG2D
Facility ID: 00770

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245218**

2. STATE VENDOR OR MEDICAID NO. (L2) **715522100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAYO CLINIC HEALTH SYSTEM - LAKE CITY**
(L4) **500 WEST GRANT STREET**
(L5) **LAKE CITY, MN** (L6) **55041**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/17/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA** **02 SNF/NF/Dual** **06 PRTF** **10 NF** **14 CORF** **03 SNF/NF/Distinct** **07 X-Ray** **11 ICF/IID** **15 ASC** **04 SNF** **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 6/8/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 7/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/20/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 1, 2016

Ms. Erin Hilligan, , Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: Project Number S5218025

Dear Ms. Hilligan:

On April 13, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 1, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 17, 2016, the Minnesota Department of Health and on May 4, 2016, the Minnesota Department of Public Safety 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 April 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2016. 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 April 1, 2016. The deficiencies not corrected are as follows:

280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being

The most serious deficiencies in your facility were found to be 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.

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 June 6, 2016. (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

An equal opportunity employer.

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 July 1, 2016. (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 July 1, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2016. 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 - Lake City is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective July 1, 2016. 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 action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to: Tamika.Brown@cms.hhs.gov.

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later

than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown by phone at (312)353-1502 or by email at Tamika.Brown@cms.hhs.gov.

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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 October 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	R 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on May 16, 17, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	{F 280}		6/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 6/8/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	R 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 280}	Continued From page 1 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the comprehensive care plan in regards to oral care for 1 of 3 residents (R31) reviewed for dental status and services. Findings include: R31 had been observed on 5/16/16, at 3:28 p.m. R31 was in bed with eyes closed with mouth slightly opened and could visualize natural lower and upper teeth. R31 had a dental appointment on 4/13/16. The Dentist consultation report included "Patient was seen for dental cleaning today. Patient has heavy plaque throughout her entire mouth. Her tissues [gums]are very red and puffy. I am sending a curved toothbrush which will help clean along the gum line. Patient needs to have teeth brushed twice a day. If she is too tired at night they can be brushed after supper." R31's care plan included, "dental visits PRN [as needed]." also in need of extensive assist from staff to meet hygiene needs. There was no updated interventions regarding the Dentist directions an returning from the dental visit on 4/13/16. R31's care guide for nursing assistants to meet the individualized residents assessed needs, provided by the facility on 5/17/16. Again the Dentist's order for brushing teeth twice daily with the curved toothbrush was not included on this guide.	{F 280}	R31 consult was sent to Physician for signature. Careplan/kardex was revised for dental services which included curved toothbrush. Oral assessment was completed. All resident care plans were updated to include dental services. New flow sheet created to be used when resident returns from consult appointment. Nursing staff will be educated on updating care plans. Education will be done on the new consultation appointment flow sheet. Audits of the newly created consult sheet to be completed two times a week by Health Unit Coordinator for 3 months, and random audits thereafter. Oral care audits will be done 4 times a week for 3 months. The QAPI team will be reviewing the audits and making necessary process changes as appropriate. DON is responsible to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	R 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET** **LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 280}	Continued From page 2 During an interview on 5/16/16, at 3:38 p.m. licensed practical nurse (LPN)-F reported the care plan did not include a dental focus. LPN-F reported the dental visit on 4/13/16 orders on return included red and puffy tissues and had sent a curved tooth brush to be used twice per day. LPN-F indicated the nursing assistant care guide instructed staff to brush and floss daily but had not been updated to include the dentist's orders. During an interview on 5/16/16, at 3:49 p.m. registered nurse (RN)-B stated the recommendations should have been added to the comprehensive care plan and care guide. During an observation on 5/16/16, at 4:15 p.m. nursing assistant (NA)-B was asked to show surveyor the curved toothbrush for R31. NA-B looked around R31's room and was not able to find the curved toothbrush. NA-B was asked, "What do you use to brush her teeth and how often?" NA-B reported she used a regular toothbrush, sometimes twice per her shift depending on what R31 had for dinner. NA-B stated most of the time R31 was cooperative with oral care. During an interview on 5/17/16, at 2:55 p.m. director of nursing (DON) indicated the care plan should have been revised to include the dentist's recommendations. Facility policy Care Plan last reviewed 1/16 included, "The care plan must be reviewed and revised (updated) as necessary, but at least every three months. Problems, goals, and approaches must be reviewed and revised when appropriate and necessary; three months is the maximum time limit. Three months may be too long and not reasonable for certain short-term goals. Care plans may need to be revised when new orders are obtained."	{F 280}		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify a non-pressure related skin injury for 1 of 3 residents (R111) reviewed for non pressure skin injuries. Findings included; R111 had been observed on 5/17/16, at 9:13 a.m. nursing assistant (NA)-O finished giving R111 a whirlpool tub bath. There was a light purple bruise the size of a small lime, and below that one was a small light purple bruise. NA-O remarked the bruises were not new because of the color. Also both feet on the second toe showed areas of redness on the "knuckle" of the toe. The third toe on the left foot had a small scabbed area with surrounding redness. NA-O was asked if she was going to report these reddened areas on the toes and NA-O said that she did not have too because they should have been reported during the first bath R111 had this week. During an interview on 5/17/16, at 10:04 a.m. licensed practical nurse (LPN)-C reported that NA-O had not reported any skin integrity issues on R111. During an interview on 5/17/16, at 10:12 a.m. registered nurse (RN)-B had been informed of R111's toe wounds and completed and	{F 309}	R111 scratch was entered into risk management. Treatment started and entered onto Treatment Record. Physician and family were notified. Care plan updated. Reviewed the bath body audit policy. Nursing Assistants to be educated on notifying nurse on change in skin condition. Nursing staff/HUCs will be re- educated on the bath body audit policy. DON /Staff Educator will observe R 111 weekly on bath day that body audit is accurate and complete for one month. DON / Staff Educator will review 6 body audits each week for 3 months. The QAPI team will review the audits and make necessary process changes as appropriate. DON is responsible to ensure compliance.	6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	R 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 4 assessment including measuring the areas of impaired skin integrity. RN-B indicated the scabbed area and redness on the third toe was not previously identified. The scab measured 0.2 centimeters (cm) by 0.2 cm with surrounding redness measurements of 1.0 cm by 0.8 cm. RN-B stated NA's are to report any areas of impaired skin integrity. During an interview on 5/17/16 at 3:00 p.m. director of nursing (DON) reported NA's monitor skin with cares and are to report to the nurse any skin concerns they find. DON explained that the nurse then assesses and treat the skin, document, and notify the physician and update any orders. Facility policy Skin Integrity-Non pressure dated 4/16 included, "Any resident with a break in skin integrity with a non-pressure area of the skin will receive prompt thorough treatment to ensure appropriate healing." The policy directed staff to: notify the nursing supervisor and document and complete appropriate assessment. The policy also gave direction to notify the physician, follow the standing orders for skin care, and update the care plan and implement monitoring schedule.	{F 309}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245218		5/17/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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

ITEM (Y4) ID Prefix	Reg. #	LSC	DATE (Y5) Correction Completed
F0164	483.10(e), 483.75(l)(4)		05/03/2016
F0279	483.20(d), 483.20(k)(1)		05/03/2016
F0281	483.20(k)(3)(i)		05/03/2016
F0282	483.20(k)(3)(ii)		05/03/2016
F0323	483.25(h)		05/03/2016
F0425	483.60(a),(b)		05/03/2016
F0431	483.60(b), (d), (e)		05/03/2016
F0441	483.65		05/03/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	6/1/2016	15425	5/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245218	A. Building 01 - MAIN BUILDING 01 B. Wing	5/4/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 05/04/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 05/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL.kfd	DATE 6/1/2016	SIGNATURE OF SURVEYOR 37008	DATE 5/4/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/29/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Protecting, maintaining and improving the health of all Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on XXXXXX, 2016.

June 1, 2016

Ms. Erin Hilligan, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: Project # S5218025

Dear Ms. Hilligan:

On May 17, 2016, 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 April 1, 2016.

State licensing orders issued pursuant to the last survey completed on April 1, 2016 and found corrected at the time of this May 17, 2016 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on April 1, 2016, found not corrected at the time of this May 17, 2016 revisit and subject to penalty assessment are as follows:

20570 - MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision - $300.00
20830 - MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General - $350.00

The details of the violations noted at the time of this revisit completed on May 17, 2016 (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, electronically acknowledge and date this form and submit 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 **$650.00** per day beginning on the day you receive this notice.

The fines shall accumulate daily until 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 or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, 18 Wood Lake Dr Se Rochester, MN 55904.

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, Health Regulation Division, 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.

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

Sincerely,

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

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ______ B. WING ______	R **05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments	{2 000}		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
An onsite follow-up visit was completed on May 16 & 17, 2016. During this onsite visit it was determined that the following two corrections orders were NOT corrected.
0570 MNRule 4658.0405 Subp. 4
0830 MN Rule 4658.0520 Subp. 1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ______ B. WING ______	R 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 000}	Continued From page 1 These two uncorrected orders will remain in effect and will be reviewed at the next onsite visit. Also uncorrected orders will be reviewed for possible penalty assessments.	{2 000}		
{2 570}	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings: Based on observation, interview, and document review, the facility failed to revise the comprehensive care plan in regards to oral care for 1 of 3 residents (R31) reviewed for dental status and services. Findings include: R31 had been observed on 5/16/16, at 3:28 p.m. R31 was in bed with eyes closed with mouth slightly opened and could visualize natural lower and upper teeth. R31 had a dental appointment on 4/13/16. The Dentist consultation report included "Patient was seen for dental cleaning today. Patient has heavy plaque throughout her entire mouth. Her tissues	{2 570}	corrected	6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 570}	Continued From page 2 [gums]are very red and puffy. I am sending a curved toothbrush which will help clean along the gum line. Patient needs to have teeth brushed twice a day. If she is too tired at night they can be brushed after supper." R31's care plan included, "dental visits PRN [as needed]." also in need of extensive assist from staff to meet hygiene needs. There was no updated interventions regarding the Dentist directions an returning from the dental visit on 4/13/16. R31's care guide for nursing assistants to meet the individualized residents assessed needs, provided by the facility on 5/17/16. Again the Dentist's order for brushing teeth twice daily with the curved toothbrush was not included on this guide. During an interview on 5/16/16, at 3:38 p.m. licensed practical nurse (LPN)-F reported the care plan did not include a dental focus. LPN-F reported the dental visit on 4/13/16 orders on return included red and puffy tissues and had sent a curved tooth brush to be used twice per day. LPN-F indicated the nursing assistant care guide instructed staff to brush and floss daily but had not been updated to include the dentist's orders. During an interview on 5/16/16, at 3:49 p.m. registered nurse (RN)-B stated the recommendations should have been added to the comprehensive care plan and care guide. During an observation on 5/16/16, at 4:15 p.m. nursing assistant (NA)-B was asked to show surveyor the curved toothbrush for R31. NA-B looked around R31's room and was not able to find the curved toothbrush. NA-B was asked, "What do you use to brush her teeth and how often?" NA-B reported she used a regular toothbrush, sometimes twice per her shift depending on what R31 had for dinner. NA-B	{2 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 570}	Continued From page 3 stated most of the time R31 was cooperative with oral care. During an interview on 5/17/16, at 2:55 p.m. director of nursing (DON) indicated the care plan should have been revised to include the dentist's recommendations. Facility policy Care Plan last reviewed 1/16 included, "The care plan must be reviewed and revised (updated) as necessary, but at least every three months. Problems, goals, and approaches must be reviewed and revised when appropriate and necessary; three months is the maximum time limit. Three months may be too long and not reasonable for certain short-term goals. Care plans may need to be revised when new orders are obtained." The original licensing order issued on April 1, 2016, will remain in effect. Also uncorrected orders will be reviewed for possible penalty assessments.	{2 570}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	{2 830}		6/15/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ______ B. WING ______	R 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 830}	Continued From page 4 This MN Requirement is not met as evidenced by: Uncorrected based on the following findings: Based on observation, interview, and document review, the facility failed to identify a non-pressure related skin injury for 1 of 3 residents (R111) reviewed for non pressure skin injuries. Findings included; R111 had been observed on 5/17/16, at 9:13 a.m. nursing assistant (NA)-O finished giving R111 a whirlpool tub bath. There was a light purple bruise the size of a small lime, and below that one was a small light purple bruise. NA-O remarked the bruises were not new because of the color. Also both feet on the second toe showed areas of redness on the "knuckle" of the toe. The third toe on the left foot had a small scabbed area with surrounding redness. NA-O was asked if she was going to report these reddened areas on the toes and NA-O said that she did not have too because they should have been reported during the first bath R111 had this week. During an interview on 5/17/16, at 10:04 a.m. licensed practical nurse (LPN)-C reported that NA-O had not reported any skin integrity issues on R111. During an interview on 5/17/16, at 10:12 a.m. registered nurse (RN)-B had been informed of R111's toe wounds and completed and assessment including measuring the areas of impaired skin integrity. RN-B indicated the scabbed area and redness on the third toe was not previously identified. The scab measured 0.2 centimeters (cm) by 0.2 cm with surrounding redness measurements of 1.0 cm by 0.8 cm. RN-B stated NA's are to report any areas of impaired skin integrity. During an interview on 5/17/16 at 3:00 p.m. director of nursing (DON) reported NA's monitor skin with cares and are to report to the nurse any	{2 830}	Corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ____ B. WING ____	R 05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

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{2 830}	Continued From page 5 skin concerns they find. DON explained that the nurse then assesses and treat the skin, document, and notify the physician and update any orders. Facility policy Skin Integrity-Non pressure dated 4/16 included, "Any resident with a break in skin integrity with a non-pressure area of the skin will receive prompt thorough treatment to ensure appropriate healing." The policy directed staff to: notify the nursing supervisor and document and complete appropriate assessment. The policy also gave direction to notify the physician, follow the standing orders for skin care, and update the care plan and implement monitoring schedule. The original licensing order issued on April 1, 2016, will remain in effect. Also uncorrected orders will be reviewed for possible penalty assessments.	{2 830}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00770 Y1	A. Building B. Wing Y2	5/17/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 05/03/2016	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 05/03/2016	ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 05/03/2016
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 05/03/2016	ID Prefix 21620 Reg. # MN Rule 4658.1345 LSC	Correction Completed 05/03/2016	ID Prefix 21665 Reg. # MN Rule 4658.1400 LSC	Correction Completed 05/03/2016
ID Prefix 21855 Reg. # MN St. Statute 144.651 Subd. 15 LSC	Correction Completed 05/03/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kf	DATE 06/01/2016	SIGNATURE OF SURVEYOR 15425	DATE 5/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

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

ID: VG2D
Facility ID: 00770

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245218**
2. STATE VENDOR OR MEDICAID NO. (L2) **715522100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAYO CLINIC HEALTH SYSTEM - LAKE CITY**
(L4) **500 WEST GRANT STREET**
(L5) **LAKE CITY, MN** (L6) **55041**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **04/01/2016** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 04/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/20/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 13, 2016

Mr. Jacob Suckow, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: Project Number S5218025

Dear Mr. Suckow:

On April 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 May 11, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 11, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 1, 2016 (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 October 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	04/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		5/3/16

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

Electronically Signed | | 04/21/2016

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promote confidentiality of medical and personal information for both oral and written forms for 2 of 2 residents (R73 and R51) reviewed for confidentiality and privacy. Findings Include: R73's family member (FM)-A was interviewed on 3/29/16 at 12:42 p.m., when asked, "Does the staff speak privately (without being overheard) about your relative's/friend's medical or behavioral condition?" FM-A responded, "No, they speak to me about concerns wherever I may be. So if I happen to be in the hall they talk to me in the hall and it is not done privately." On 03/31/2016 at 1:57 p.m., the director of nursing (DON) stated she expected staff to communicate with families in a private area. The DON stated speaking to a family member in the hallway about a resident's medical or behavioral concerns would not be private. The DON confirmed the facility policy instructed staff to not discuss patient information in a public area. The Privacy/Dignity Policy with a review date of 1/16 included, "...Patient information will not be discussed in a public area."	F 164	Time out screens have been reduced to the two minutes and nursing staff have been educated to lock application prior to leaving application. All staff will be re-educated on HIPPA and to update residents/families in resident s room or in a private place, not if any public area. Audits will be done 2 times a week by Social Services, Activities, Night Charge Nurse and Health Unit Coordinators times 3 months and random thereafter. Results will be reviewed by QAPI team.	

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F 164	Continued From page 2 R51's medical information was in full view of anyone in the country view hall on 03/31/16, at 7:11 a.m. A computer screen mounted on the hallway wall was open, and any person that walked down the hallway pass the screen was able to view the information on the screen. The screen identified the following health information for R51: R51's first and last name, room number, weekly tub bath, bowel movements, laniseptic cream [skin protectant] to sacrum every shift, Teds [compression stockings] on in a.m., calmoseptine [topical ointment] to upper thighs and peri-area with cares, turn and reposition every two hours, every shift bed mobility, check areas of moisture abdominal folds, under breasts, buttocks crease daily during care, daily with a.m. cares to check redness under breasts, abdominal folds, and buttocks crease, grippy socks on when in bed at all times and Vaseline to corners of mouth every a.m. On 3/31/16, at 7:11 a.m., a construction worker walked by the screen. At 7:12 a.m., registered nurse (RN)-E, a construction worker and nursing assistant (NA)-G walked by the screen. At 7:15 a.m., a construction worker walked by the screen. At 7:17 a.m., NA-G walked by the screen. At 7:18 a.m., nursing assistant (NA)-E walked by the screen. At 7:20 a.m., construction worker (CW)-C walked by the screen and verified there were three construction workers currently working on construction in the country view hallway. At 7:22 a.m., one resident was left by staff sitting in a wheelchair in front of the screen and another resident walked by the screen independently with a walker. At no time did the staff secure the resident's information on the computer from unauthorized visual access.	F 164		

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F 164	Continued From page 3 On 3/31/16, at 7:25 a.m., NA-G verified the screen was open and R51's health information was on the screen. NA-G stated sometimes the screen does not close and NA-G then closed the screen. On 3/31/16, at 1:40 p.m., the DON stated she would expect the screen to be closed out when the staff leaves the screen. The DON provided information of the HIPPA [Health Insurance Portability and Accountability Act] passed in 1996, which indicated protected health information, anything that identifies the individual: computer monitors are not exposed to public view.	F 164		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		5/3/16

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F 279	Continued From page 4 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a plan of care for 1 of 1 resident (R111) reviewed for dental services. Findings include: R111's admission record indicated the resident was admitted to the facility on 11/18/15. R111's admission Minimum Data Set (MDS), dated 11/24/15, indicated that the resident had no dental issues. R111 needed extensive assistance by one staff member with personal hygiene. R111's quarterly MDS did not indicate whether the resident had any problems with her teeth. It specified that R111 needed extensive assistance by two staff members with personal hygiene. R111's care plan, dated 11/18/15, indicated that the resident was unable to groom herself independently and needed extensive assistance related to her dementia. R111's kardex report (used to instruct nursing assistants on cares for each resident), dated 11/18/15, did not contain any information in regards to oral care. R111's oral exam, dated 2/22/16, stated that the resident had artificial teeth which were worn most of the time. The resident was observed to have food particles or tartar in two spots on her artificial teeth.	F 279	A new comprehensive oral assessment has been developed. R111 had an oral assessment done and care plan was updated to include dental services. All residents will have the new oral assessment completed per the MDS schedule and prn. Care plan policy and procedure was reviewed. Staff to be re-educated on developing careplans. Audits to be completed by Nurse Managers two times each week for 3 months. Results will be reviewed by QAPI team.	

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F 279	Continued From page 5	F 279		

R111's nutritional assessment, dated 2/26/16, stated that the resident had a chewing and dentition problem.

During an observation on 3/29/16 at 9:29 a.m., R111 was observed to have two missing teeth on her lower palate.

During an observation of cares on 3/31/16 at 7:37 a.m., nursing assistant (NA)-H assisted the resident with dressing. NA-H did not perform oral hygiene at this time.

When interviewed on 3/31/16 at 8:16 a.m. nursing assistant (NA)-H stated that R111 had dentures. NA-H described the resident as having a full plate of dentures on the top and a partial set of dentures on the bottom. NA-H stated that the resident had not been leaving them in. Currently, the dentures were placed in a cup in R111's room. NA-H stated that she put a denture tablet in the cup with water to clean the dentures at night. NA-H stated that after breakfast, she would clean the resident's remaining teeth with a pink swab. NA-H stated that she would do this after meals.

During an observation on 3/31/16 at 9:44 a.m. with licensed practical nurse (LPN)-B, R111's oral cavity was assessed. The resident's dentures were currently in a cup of water. The resident had a few teeth remaining on her bottom palate. LPN-B stated that R111 did not keep her dentures in her mouth.

When interviewed on 3/31/16 at 9:54 a.m., licensed practical nurse (LPN)-B stated that the nursing assistants perform oral cares for R111 by brushing her teeth with a tooth brush. LPN-B

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F 279	Continued From page 6 stated that the staff should be performing oral cares twice a day. LPN-B stated that it depended on the resident if she allowed the staff to use a toothbrush; LPN-B stated that if the resident started striking out then they staff would attempt to use oral swabs to complete oral cares. LPN-B stated that the resident had struck out at staff in the past. LPN-B stated that specific oral cares for R111 should have probably been care planned. When interviewed on 3/31/16 at 10:45 a.m., nursing assistant (NA)-K stated that R111 had dentures. R111 would have her dentures cleaned in the morning and evening. NA-K described using mouthwash prior to cleaning R111's mouth with pink oral swabs. NA-K stated that she would wait after R111 had eaten a meal in the morning to perform oral cares. NA-K stated that she would first explain to R111 what she was about to do when performing oral cares in order to avoid having the resident potentially strike out at her. When interviewed on 4/1/16 at 10:18 a.m., nursing assistant (NA)-J stated that she would make sure that R111's dentures were brushed. NA-J would swab R111's mouth with a pink swab. NA-J stated that she would do that every shift while she worked with R111. NA-J stated that she was afraid to use a toothbrush with R111 as the resident would bite down and not give it back. NA-J stated that when the resident was first admitted to the facility, she would let the staff use a toothbrush when cleaning her teeth; now, NA-J described that R111 would only bite down on a toothbrush and not let the staff clean her teeth. When interviewed on 4/1/16 at 12:54 p.m., the director of nursing (DON) stated that R111 should have had an individualized care plan regarding	F 279		

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F 279	Continued From page 7 her oral hygiene. The DON stated that the information would have been put in the Kardex so the nursing assistants would know how to care for R111 as well. The facility Care Plan Policy, review date 1/16, indicated V. [five] concerns and problems B. Sources are, but not limited to: 8. Problems related to preventive care. 11. All problems requiring care. VII. [seven] Approach/Plan C. Individualized care for the unique needs of the resident. H. List preventive measures. IX. [nine] Review Date B. The care plan must be reviewed and revised (updated) as necessary. XII. [12] Resident Care Plan Documentation and Use of the Plan C. The resident care plan is used to plan and assign care for all disciplines. E. The resident care plan must be kept current at all times. F. Develop procedures to communicate all care plan information to the resident care staff.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		5/3/16

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F 280	Continued From page 8 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include behaviors for 1 of 1 resident (R111) reviewed for behaviors; failed to revise the care plan to include oral status for 1 of 3 residents (R42) reviewed for dental services and failed to revise the care plan to include the risk for bruising for 1 of 4 residents (R68) reviewed for skin conditions. Findings include: R111's admission record, dated 11/18/15, indicated the resident had a diagnosis of unspecified dementia without behavioral disturbance. R111's quarterly MDS, dated 2/22/16, indicated that the resident had physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) on 1 to 3 days in the past 7 days. R111's care plan, dated 11/18/15, indicated that the resident had cognitive loss due to dementia, depression and disorientation. It recommended to watch for evidence of escalation of behaviors. If behavior escalates, make sure that the resident was safe and to come back to R111 at a later time. The care plan recommended using basic	F 280	R111 careplan was revised to include behaviors, R42 for dental services and R68 for skin conditions. R42 had oral assessment done with careplan updated. R42 care profile has been updated to current status. Skin integrity task in Point of Care in Point Click Care has been initiated to auto populate for all residents, to capture noted skin issues, document by Nursing Assistants, with prompt to report to Nurse. Resident care plans will be reviewed and revised as indicated per MDS schedule, upon noted changes and prn. Nursing staff to be re-educated to necessary changes and revision of care plans. Audits to be completed two times each week by DON or designee for 3 months. Results will be reviewed by QAPI team.	

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F 280	Continued From page 9	F 280		

3-5 word one-step commands; it advised when R111 was agitated (tossing and turning) have the resident up in her chair, when the resident was calm assist the resident back to her bed; when R111 was restless at night, staff were to assist the resident to her Broda chair at night and bring to the nurses station in addition to offering a warm blanket; it advised to monitor the interactions between R111 and other residents, staff and family members; it directed the staff to monitor R111's mood and behavior state.

R111's pain assessment, dated 2/22/16, indicated that the resident would occasionally strike out. It recommended to continue to monitor the resident and offer non-pharmacological interventions and/or medications as ordered. The doctor should be notified as needed.

R111's Kardex report (a guide for nursing assistants on caring for residents), dated 4/1/16, directed the nursing assistants in regards to any behaviors if the resident exhibited any restlessness, R111 might be cold. It instructed the nursing assistants' to put on R111's purple robe as this has brought comfort in the past.

R111's behavior summary report, reviewed from 2/12/16 through 4/1/16, indicated that the resident exhibited 4 episodes of biting, 17 episodes of grabbing and 2 episodes of kicking/hitting.

R111's progress notes, reviewed from 2/1/16 through 3/31/16 indicated the resident exhibited two episodes of striking out at staff. One episode occurred on 2/19/16 and a second episode occurred on 3/6/16. On 2/19/16, the staff began monitoring for pain in R111's feet due to her striking out at staff when foot cares were

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F 280	Continued From page 10 attempted. On 3/6/16, no interventions were done. When interviewed on 3/30/16 at 1:34 p.m., licensed practical nurse (LPN)-B stated that R111 would strike out at staff mostly at night, approximately once a week. LPN-B stated that at first the nursing assistants thought it might be due to the need to go to the bathroom but they determined it was not that. LPN-B stated that it appeared to be random acts with no rhyme or reason to the striking out. When interviewed on 3/31/16 at 9:54 a.m., LPN-B stated that the nursing assistants would have to switch from a toothbrush to an oral swab if R111 had struck out at the staff. LPN-B stated that R111 had struck out at staff in the past. When interviewed on 3/31/16 at 10:45 a.m., nursing assistant (NA)-K stated that R111 would grab at staff when performing oral cares. NA-K stated that R111 would strike out at staff "...if she doesn't like what you are doing." NA-K stated that R111 would strike out at staff when doing oral cares. When interviewed on 4/1/16 at 10:16 a.m., NA-J stated that R111 did strike out at staff. NA-J stated that R111 would strike out at staff when doing cares approximately once or twice a week. When interviewed on 4/1/16 at 12:20 p.m., RN-G stated that R111 had exhibited physical behavior from 1 to 3 days on the quarterly MDS. The physical behaviors that this would have included were: grabbing, pinching, scratching and spitting. RN-G stated this was documented only one time by the nursing assistants. RN-G stated there was	F 280		

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no assessment for behaviors done on resident's. What would happen, if behaviors were observed, the nursing staff would monitor and document on any behaviors. This would have been in the nursing notes. Nursing assistants would also chart in the electronic system called point of care (POC). RN-G stated that if there was any documentation it would be in the nursing notes. RN-G did stated that the resident's behaviors should have been care planned.

When interviewed on 4/1/16 at 12:49 p.m., the director of nursing (DON) stated that the facility should have care planned the behaviors (specific to hitting). She stated that there should be interventions care planned which addressed these behaviors. The DON stated that the facility did not have an assessment specifically for a resident's behaviors. She explained that if a resident exhibited any behaviors, they would then tell the nurse. Once notified, the nurse would then address the behavior by initiating an "active problem" charting for two weeks. This was free texting where the nursing staff would be charting on the resident's actions over the course of two weeks. It would then be addressed from there.

Review of the facility policy titled, "Behavior Monitoring/ side effect monitoring (1/16)." The policy stated that the care plan would be initiated which utilized the date collected from the target behavior documentation on admission (if present), quarterly and with a significant change. It stated that the social worker, or designee, was responsible for developing and/or updating the resident mood and behavior sections of the care plan. The goal and interventions would be identified as discussed in the interdisciplinary team (IDT).

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R42"s care plan dated 6/24/2014, indicated, "DENTAL CARE: I have a potential for impaired r/t [related to] dentures."

R42 was observed on 3/29/2016, at 9:43 a.m. in her room, appeared to have no teeth and was not wearing dentures.

R42 was observed on 03/31/2016, at 9:44 a.m. in her room, appeared to have no teeth and was not wearing dentures.

R42's annual Minimum Data Set Assessment (MDS) dated 4/29/15, indicated R42 had no natural teeth.

R42's Care Area Assessment (CAA) dated 4/29/15, indicated R42 had no natural teeth, and did not include a summary analysis to direct what should be included on the care plan for dental for R42.

R42's oral exam dated 1/13/16, indicated R42 had no natural teeth, did not wear dentures and the care plan was current.

R42's oral exam dated 10/14/15, indicated R42 had no natural teeth, did not wear dentures and the care plan was current.

R42's oral exam dated 4/16/15, indicated R42 had no natural teeth, did not wear dentures.

On 3/31/2016, at 10:25 a.m. nursing assistant (NA)-C stated she did not think R42 had any natural teeth and did not wear dentures.

On 3/31/2016, at 1:08 p.m. the director of nursing (DON) stated the oral assessment completed

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1/13/16 indicated R42 had no natural teeth and did not have dentures. The DON stated the care plan indicated R42 was wearing dentures. The DON stated R42 did not have any dentures at the facility for her use and the care plan should have been revised to reflect R42 no longer wore her dentures.

The Care Plan policy with a review date of 1/16, indicated, "...The care plan must be reviewed and revised (updated) as necessary, but at least every three months..."

R68's care plan, print date 4/1/16, identified potential for alteration in skin integrity, incontinence and decreased mobility with interventions of: daily check for redness with a.m. cares under abdominal fold and buttocks crease and Aveeno lotion on back and arms BID (twice daily).

On 3/28/16, at 4:43 p.m., observation revealed R68 had two dark purple bruises on top of R68's right hand/wrist area. R68 stated the bruises were from old age.

R68's progress notes identified the following:
6/28/15, new bruise right forearm, 13 cm (centimeters) by 6.7 cm. R68 obtained the bruise when out on an outing.
12/15/15, bruise left knee, measured 2.7 cm by 3.2 cm dark purple in color, R68 does not remember what he bumped.

On 3/30/16, at 11:06 a.m., nursing assistant (NA)-H verified R68 had bruising on his right hand/wrist area. R68 stated at the time the bruising was from his watch. NA-H stated the facility system was the NA's usually report to the

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F 280	Continued From page 14 charge nurse when bruising is noted, then the charge nurse makes a report. On 3/30/16, at 11:36 a.m., registered nurse (RN)-D verified R68 had two bruises located on his right hand/wrist area. RN-D stated we were not aware of the bruising. RN-D stated the nurse usually identified bruising during body audits on bath days or the NAs would report the bruising. Then a risk assessment would be completed, the size of the bruise would be documented and the bruising would be monitored until healed. On 3/30/16, at 11:41 a.m., NA-I stated we assist R68 with all of his cares in the a.m. NA-I stated she had assisted R68 with getting dressed this a.m. NA-I stated, when queried if R68 had any skin concerns or bruising, R68 had very fragile skin, I put lotion on R68's arms and shoulders, I did not notice any skin concerns and R68 always has those bruises. On 4/1/16, at 10:40 a.m., the director of nursing stated she would expect bruising to be identified on the care plan as a problem area, as R68 has had bruising before. The facility Care Plan Policy, review date 1/16, indicated V. [five] concerns and problems B. Sources are, but not limited to: 8. Problems related to preventive care. 11. All problems requiring care. VII. [seven] Approach/Plan C. Individualized care for the unique needs of the resident. H. List preventive measures. IX. [nine] Review Date B. The care plan must be reviewed and revised (updated) as necessary. XII. [12] Resident Care Plan Documentation and Use of the Plan C. The resident care plan is used to plan and assign care for all disciplines. E. The resident	F 280		

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F 280	Continued From page 15 care plan must be kept current at all times. F. Develop procedures to communicate all care plan information to the resident care staff.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop an initial care plan with interventions based on health needs at the time of admission for 1 of 1 resident (R125) reviewed for dialysis services; and failed to ensure proper technique of administration of an inhaler medication for 1 of 1 residents (R10) observed for medication administration. Findings include: LACK OF INITIAL DIALYSIS CARE PLAN TO ADDRESS HEALTH NEEDS: R125 was admitted on 3/23/16, with diagnosis of chronic kidney disease according to facility admission record. During interview on 3/30/16, at 11:35 a.m., R125 stated received dialysis on Tuesdays, Thursdays, and Saturdays. R125 revealed the dialysis access sight was a fistula located in the front of the left upper arm. The fistula site was uncovered, clean and dry. R125 stated no diet or fluid restriction. Observations at that time revealed no water glass or pitcher in the room.	F 281	Resident R125 discharged from facility on 3/23/16. Policy and procedure for Hemodialysis residents was revised. Education on Dialysis was added to our nursing cheat sheet books and to Nurse and Nursing Assistant preceptor sheet. Charge nurse admit/readmit check list revised to include update careplan/Kardex if on dialysis. Nursing staff to be educated on dialysis care of Bruit/Thrill. Audit has been developed for dialysis care for future admissions and will be completed upon dialysis admission by DON or designee. Resident R10 will be asked to swish and spit with water post taking her inhaler. Nursing staff to be re-educated to give inhalation medication according to directions. Pharmacy Nurse Consultant will do random med pass audits every week for 3 months. Results of audits to DON for any follow-up required. Audits will be reviewed by QAPI team.	5/3/16

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R125's admission progress note 3/23/16, identified R125 was alert and oriented, received a renal diet and fistula on left arm.

Document review of facility pre-admission clinical assessment/interim (interim or initial care plan to identify needed health needs prior to the Comprehensive care plan completed 21 days post admission) care plan dated 3/23/16, identified diagnosis of renal insufficiency. The interim care plan lacked evidence of any dialysis care interventions such as: risk factors, potential complications and/or specific dialysis related care needs, special nutritional and fluid volume needs, risks for adverse medication effects, care of the access site, infection control measures, skin care measures, monitoring of vital signs, weights and other monitoring requirements, such as before and after dialysis treatments, instructions for giving medications (to prevent dialysis treatments removing medication from the resident's system), coordinates care between the facility and dialysis center, and did not address, "Do Not Resuscitate" orders and advance directives.

Document review of physician orders dated 3/24/16, revealed orders to monitor dialysis port on left antecubital (front surface of forearm), and make sure bruit is heard with stethoscope and thrill felt with palpation, every day and evening shift.

During interview on 3/30/16, at 11:41 a.m., registered nurse (RN)-A stated not aware if R125 received fluid restriction. RN-A stated did not know what to do for R125 when returned from dialysis. RN-A stated if bleeding at fistula site, would apply pressure and call charge nurse.

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F 281	Continued From page 17 During interview on 3/30/16, at 11:50 a.m., nursing assistant (NA)-A stated worked on R125's wing. NA-A stated not aware of location of dialysis access site, and if bleeding at site would call nurse. NA-A stated R125 was a new admission, had cared for R125 one day, and was scheduled for dialysis the following day. NA-A stated not aware of any special diet and did not know if fluids were restricted. During interview on 3/30/16, at 11:55 a.m., RN-A looked at R125's treatment administration record (TAR) and stated the only dialysis treatment was for nurse to monitor dialysis port on left arm making sure the bruit was heard with a stethoscope and thrill felt with palpitation every day and evening shift. RN-A verified the TAR indicated licensed practical nurse (LPN)-A had already completed bruit and thrill check for that morning. However, during interview at that time, LPN-A stated had observed the dialysis port and had not monitored the bruit and thrill. When asked to observe the bruit and thrill check, RN-A and LPN-A stated they did not know how to monitor for bruit and thrill. LPN-A stated would get another nurse and left the floor. During interview on 3/31/16, at 1:00 a.m., director of nursing stated she expected dialysis resident care plan to be comprehensive and completed timely. Document review of facility Care of Dialysis Resident policy review date of 1/2016, revealed although the policy addressed comprehensive care plan for dialysis care, the policy did not address initial dialysis care plan.	F 281		

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LACK OF GIVING INHALATION MEDICATION ACCORDING TO DIRECTIONS:

R10's admission record, dated 10/5/2012, indicated the resident had a diagnosis of asthma.

R10's order summary report, dated 8/3/2011, indicated that R10 was prescribed Flovent HFA Aerosol 220 mcg/act: 2 puffs by inhalation two times a day related to asthma.

R10's medication administration record (MAR), reviewed from 3/1/16 through 3/31/16, indicated that the resident had been receiving the Flovent HFA Aerosol medication as ordered.

During an observation of a medication administration on 3/31/16 at 8:52 a.m., licensed practical nurse (LPN)-C set up R10's medications. R10 had tablets along with the Flovent inhaler to take to R10. LPN-C knocked on R10's door and explained to the resident that it was time for her medications. R10 raised up in bed, after the inhaler had been shaken, LPN-C handed the inhaler to the resident. R10 took two puffs from the inhaler. Once completed, LPN-C handed a soufflé cup to R10 that contained tablets along with a cup of water. R10 then took her medications and sipped water after taking a tablet. R10 never rinsed her mouth out after using the Flovent inhaler before taking the oral medications. When asked why the resident was not advised to rinse her mouth out after using the Flovent inhaler, LPN-C stated that because the resident took sips of water after swallowing her tablets, that sufficed as rinsing her mouth out. The label on the Flovent inhaler stated to rinse the mouth out with water after use.

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F 281	Continued From page 19 When interviewed on 4/1/16 at 12:43 p.m., the director of nursing (DON) stated that the resident should have rinsed her mouth out with water directly after using the Flovent inhaler. Review of the facility policy titled, "Administration of Metered Dose Inhaler (1/16)," it did not contain any information on the need to rinse the mouth out after usage even though the Food and Drug Administration (FDA) website regarding proper usage of the Flovent HFA inhaler instructed the user to rinse the mouth out after usage in order to prevent a fungal infection from occurring in some patients.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan related to diet orders for 1 of 3 residents (R85) reviewed for nutrition and the facility failed to follow the care plan to observe skin with daily cares for 1 of 3 residents (R86) observed to have bruises, reviewed for non pressure related skin conditions. Findings include: LACK OF FOLLOWING CARE PLANNED DIET:	F 282	Thickened liquids policy was revised. Nursing/Dietary staff to be re-educated to provide services and treatments as directed in the comprehensive care plan/Kardex, and dietary card at table. Audit to be completed by Dietary Supervisors each meal two times each week, for 3 months. Results will be reviewed by QAPI team. R86, skin integrity task has been initialized for documentation of skin integrity every shift in the point of care	5/3/16

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R85's care plan, print date 3/31/16, identified R85 has a risk for fluid/electrolyte imbalance related to poor intake, nectar restriction with interventions of discontinue from speech therapy services, on mechanical soft textures and nectar thick consistency, okay for free water between meals. R85 is at risk for inadequate intake related to significant weight loss noted since admission, decreased appetite and intake with interventions of high kcal, high protein kcal, with nectar liquids.

R85's physician orders, dated 3/7/16, identified an order for high protein, high calorie diet, mechanical soft texture and patient okay for free water protocol, thin water between meals.

On 3/30/16, at 12:02 p.m., R85 was observed sitting in a wheelchair at a dining room table for the noon meal. R85 had a 240 cc (cubic centimeters) of regular water, 240 cc of nectar thick orange drink and 120 cc of nectar thick ensure chocolate drink, a small bowl of cottage cheese with two peaches on top, hamburger chowder, a piece of iced oatmeal cake and a slice of bread. R85 was observed to eat independently. Nursing assistant (NA)-G was observed to be sitting at the same dining room table assisting another resident with eating and was encouraging R85 to eat during the meal. R85's dietary sheet of paper on the table next to R85's food, indicated diet: high protein, high calorie, mechanical soft, liquid nectar thick.

On 3/30/16, at 12:25 p.m., registered nurse (RN)-D verified R85 had regular water.

On 3/30/16, at 12:27 p.m., dietary manager (DM)-B looked at R85's dietary sheet on the table and stated R85 should not have thin [regular]

Provider's Plan of Correction (F 282, continued):

application.
Skin integrity task in Point of Care in Point Click Care has been initiated to auto populate for all residents, to capture noted skin issues, document by Nursing Assistants, with prompt to report to Nurse. Re-education to all nursing staff on importance of skin integrity observation, reporting and follow-up documentation.

Audit to be completed by DON or designee, and Nurse Managers two times each week for three months. Results will be reviewed by QAPI team.

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water at meal time. DM-B then removed the full glass (240 cc) of regular water from the table. DM-B stated R85 was able to have regular water 30 minutes before or after meals and in R85's room between meals. DM-B stated R85 was to have nectar thickened liquids during meals. DM-B stated the staff should have removed the water from the table when R85 was served her meal.

On 3/31/16, at 9:44 a.m., the DM-B stated the dietary sheets were part of the residents care plan.

On 3/31/16, at 1:42 p.m., the director of nursing (DON) stated that would be wrong for R85 to have regular water at meal time and R85 should have regular water between meals if that is what R85's care plan and physician orders indicate.
LACK OF MONITORING SKIN STATUS PER CARE PLAN:
R86's plan of care dated 10/1014 instructed staff to, "monitor my skin with cares and with weekly bath."

R86 was observed on 3/28/16, at 4:49 p.m. to have a bruises on the top of his right and left hands and right and left forearms with no documentation of these being identified by the staff.

However, there was documentation of bruising after the surveyor brought these bruises to the attention of the staff on 3/31/16. The progress note dated 3/31/16 indicated, "New Bruise or Follow up: Bruising found on resident left forearm measuring 2 x 1.2 cm [centimeters], 1 x 1.5 cm 3 x 2.4 cm, bruising also found on right elbow 19 x 2 cm, 4 x 8 cm and 3 x 1.5 cm. Information on Bruise: Bruising purple to light purple in color,

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resident denies any pain." Following this progress note was another progress note dated 3/31/16 which said, "New Bruise or Follow up: Bruises also found on left hand 1 x 1 cm [centimeters], 8 x 7 cm, 3 x 2 cm, right hand 14 x 8 cm."

On 3/31/2016, at 10:25 a.m. nursing assistant (NA)-C stated residents' skin was monitored for bruises on their bath days when a complete skin assessment was completed by a nurse. NA-C also stated if we see any new concerns with bruising during daily cares, when we are washing them up in the morning, we alert the nurse. NA-C stated she was unaware of any bruising on R86 at this time.

On 03/31/2016, at 12:51 p.m. the director of nursing (DON) stated there was no documentation in the medical record regarding the bruising on R86's arms or hands. The DON stated she expected staff to document and monitor bruises for healing. The DON stated on bath days a full skin assessment was completed by the nurse. The DON stated nursing assistants should be looking at skin during morning and evening cares and notify the nurse of any bruising. The DON stated residents' skin should be looked on a daily basis. The DON stated the care plan instructed staff to, " monitor my skin with cares and with weekly bath" and confirmed the staff did not follow the plan of care to identify R86's bruising.

The facility Care Plan Policy, review date 1/16, indicated V. [five] concerns and problems B. Sources are, but not limited to: 8. Problems related to preventive care. 11. All problems requiring care. VII. [seven] Approach/Plan C. Individualized care for the unique needs of the

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F 282	Continued From page 23 resident. H. List preventive measures. XII. [12] Resident Care Plan Documentation and Use of the Plan C. The resident care plan is used to plan and assign care for all disciplines. F. Develop procedures to communicate all care plan information to the resident care staff.	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R125) who received dialysis services, had initial care plan to direct dialysis care, failed to ensure staff were trained in dialysis cares and failed to coordinate care with the dialysis center; in addition the facility failed to identify non-pressure related skin concerns for 1 of 4 residents (R86) reviewed for skin; failed to identify missing teeth on the comprehensive oral assessment for 1 of 3 residents (R86) reviewed for dental status and services; failed to identify and monitor bruising for 1 of 4 residents (R68) reviewed for skin; failed to ensure documentation of physician notification for a change of skin condition for 1 of 4 residents (R61) reviewed for skin condition; failed to follow a physician's order to obtain a lab value for 1 of 1 residents (R77) reviewed.	F 309	R 125 has been discharged from facility on 3/23/16. Policy and procedure for residents receiving dialysis will be reviewed and revised. An initial care plan was developed in the electronic healthy record to be utilized and individualized upon admission to facilitate immediate dialysis cares. Nursing staff to be trained to its use. Nursing staff will be re-educated on careplan/kardex for dialysis resident. System for communication between facility and dialysis provider has been revised and staff to be educated to system. Audit has been developed for dialysis care for future admissions and will be	5/3/16

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F 309	Continued From page 24 Findings include: LACK OF INITIAL CARE PLAN INTERVENTIONS TO ADDRESS DIALYSIS STATUS: Although R125 was new to dialysis treatments and had received three treatments since admission to the facility, there was no coordination of care completed with the dialysis center and facility to ensure R125 tolerated dialysis as follows: R125 was admitted on 3/23/16, with diagnosis of chronic kidney disease according to facility admission record. R125's admission progress note 3/23/16, identified R125 was alert and oriented, received a renal diet and fistula on left arm. During interview on 3/30/16, at 11:35 a.m., R125 stated received dialysis on Tuesdays, Thursdays, and Saturdays and had no fluid restriction. R125 revealed the dialysis access sight was a fistula located in the front of the left upper arm. During observations at this time the fistula site was uncovered, clean and dry. Document review of physician orders dated 3/24/16, revealed orders to monitor dialysis port on left antecubital (front surface of forearm), and make sure bruit is heard with stethoscope and thrill felt with palpation, every day and evening shift. Document review of facility pre-admission clinical assessment/interim care plan dated 3/23/16, identified diagnosis of renal insufficiency. The	F 309	completed upon dialysis admission by DON or designee. Results will be reviewed by QAPI team. Resident R61 passed away on 4/5/16. R86 and R68 skin integrity task has been initialized for documentation of skin integrity every shift in the point of care application. A new Skin integrity assessment has been developed and R86 and R68 will have completed with new assessment. Care plans reviewed and revised as indicated. Skin integrity task in Point of Care in Point Click Care has been initiated to auto populate for all residents, to capture noted skin issues, document by Nursing Assistants, with prompt to report to Nurse. Nursing staff to be trained on skin integrity process. Audit to be completed by DON or designee, and Nurse Managers two times each week for three months. Results will be reviewed by QAPI team. R61 passed away on 4/5/16. Nursing staff have been re-educated on physician notification and use of the change in condition assessment. Nursing staff will also be educated to put FYI faxes in the chart posting sending to Physician/FNP. Audit to be completed by DON or designee one time each week for three months. Results will be reviewed by QAPI team. Results will be reviewed by QAPI team. A new comprehensive oral assessment has been developed and the oral assessment will be completed on R86.	

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F 309	Continued From page 25 interim care plan lacked evidence of any dialysis care interventions such as: risk factors, potential complications and/or specific dialysis related care needs, special nutritional and fluid volume needs, risks for adverse medication effects, care of the access site, infection control measures, skin care measures, monitoring of vital signs, weights and other monitoring requirements, such as before and after dialysis treatments, instructions for giving medications (to prevent dialysis treatments removing medication from the resident's system), coordinates care between the facility and dialysis center, and did not address the "Do Not Resuscitate" orders and advance directives. During interview on 3/30/16, at 11:41 a.m., registered nurse (RN)-A stated not aware if R125 received fluid restriction. RN-A stated did not know what to do for R125 when returned from dialysis. RN-A stated if bleeding at fistula site, would apply pressure and call charge nurse. During interview on 3/30/16, at 11:50 a.m., nursing assistant (NA)-A stated worked on R125's hall. NA-A stated not aware of location of dialysis access site, and if bleeding at site NA-A would call nurse. NA-A stated R125 was a new admission, had cared for R125 one day, and was scheduled for dialysis the following day. NA-A stated not aware of any special diet and did not know if fluids were restricted. During interview on 3/30/16, at 11:55 a.m., RN-A looked at R125's treatment administration record (TAR) and stated the only dialysis treatment was for nurse to monitor dialysis port on left arm making sure the bruit was heard with a stethoscope and thrill felt with palpitation every day and evening shift. RN-A verified the TAR	F 309	Nursing staff to be educated on new oral assessment Audit to be completed by Nurse Managers two times each week for three months. R77 care plan has been reviewed and revised as indicated. Lab policy has been revised. HUCs/Nursing will be re-educated on system for lab orders and revised lab policy. Audit to be completed by Nurse Mangers two times each week for 3 months. Results will be reviewed by QAPI team.	

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indicated licensed practical nurse-A (LPN-A) had already completed bruit and thrill check for that morning. During interview at that time, LPN-A stated had observed the dialysis port and had not monitored the bruit and thrill. When asked to observe the bruit and thrill check, RN-A and LPN-A stated they did not know how to monitor for bruit and thrill. LPN-A stated would get another nurse and left the floor.

During interview on 3/30/16, at 1:18 p.m.,NA-B verified was assigned to R125's hallway that day. NA-B stated not aware of location of dialysis access sight and did not know if received fluid restriction.

During interview on 3/30/16, at 1:20 p.m., RN-B stated the nurse who is responsible for R125's cares for the day needs to check the calendar and communicated dialysis appointments to nursing assistants who care for R125 on days of dialysis. RN-B stated expected nursing assistants to provide care according to nursing assistant kardex in facility computer system. At that time, RN-B verified the kardex identified R125 voided 1-2 times a day, no blood pressure in left arm, and daily weight. RN-B verified the nursing assistant kardex lacked identification of the dialysis port site, care of dialysis resident, diet, fluids, and emergency care. RN-B stated, if bleeding at dialysis port sight, staff knew to get the nurse. RN-B stated R125 had three dialysis visits since admission and verified no communication reports received from dialysis. RN-B stated R125 was not on fluid restriction. RN-B stated medications were administered as ordered and not aware of any medications that were to be held prior to dialysis treatments. RN-B verified R125's preadmission clinical assessment

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/interim care plan dated 3/23/16, indicated diagnosis of renal insufficiency, and no identification of dialysis care.

During interview on 3/31/16, at 1:00 a.m., director of nursing stated she expected dialysis resident care plan to have dialysis needs identified.

Document review of facility Care of Dialysis Resident policy review date of 1/2016, revealed the following:

2. B. Nursing-frequent communication before and after dialysis will occur. A dialysis treatment record will be used by the dialysis provider during treatment and given to the skilled nursing facility staff after treatment as a summary and communication record. Although the policy addressed comprehensive care plan for dialysis care, the policy did not address initial dialysis care plan.
IDENTIFICATION AND MONITORING OF NON PRESSURE RELATED SKIN CONCERNS:

R86 was observed on 3/28/16, at 4:49 p.m. to have a bruises on the top of his right and left hands and right and left forearms with no documentation of these being found until the staff were informed of them by this surveyor on 3/31/16.

R86's signed physician orders included prednisone tablet give 5 mg (milligrams) by mouth in the morning for joint pain.

R86's body audit bath forms dated 3/28/16, 3/21/16, 3/14/16 and 3/7/16 did not identify any bruising to the tops of R86's hands or forearms.

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R86's progress note dated 3/31/16 indicated, "New Bruise or Follow up: Bruising found on resident left forearm measuring 2 x 1.2 cm [centimeters] , 1 x 1.5 cm 3 x 2.4 cm, bruising also found on right elbow 19 x 2 cm, 4 x 8 cm and 3 x 1.5 cm. Information on Bruise: Bruising purple to light purple in color, resident denies any pain."

R86's progress note dated 3/31/16 indicated, "New Bruise or Follow up: Bruises also found on left hand 1 x 1 cm [centimeters], 8 x 7 cm, 3 x 2 cm, right hand 14 x 8 cm."

R86's plan of care dated 10/1014 instructed staff to, "monitor my skin with cares and with weekly bath."

On 3/31/2016, at 10:25 a.m. nursing assistant (NA)-C stated residents' skin was monitored for bruises on their bath days when a complete skin assessment was completed by a nurse. NA-C also stated if we see any new concerns with bruising during daily cares, when we are washing them up in the morning, we alert the nurse. NA-C stated she was unaware of any bruising on R86 at this time.

On 03/31/2016, at 12:51 p.m. the director of nursing stated there was no documentation in the medical record regarding the bruising on R86's arms or hands. The DON stated she expected staff to document and monitor bruises for healing. The DON stated on bath days a full skin assessment was completed by the nurse. The DON stated nursing assistants should be looking at skin during morning and evening cares and notify the nurse of any bruising. The DON stated residents' skin should be looked on a daily basis.

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A policy and procedure for monitoring non pressure related skin conditions was requested and none provided.

LACK OF COMPREHENSIVE DENTAL ASSESSMENT AND DEVELOPMENT OF INTERVENTIONS BASED ON THIS ASSESSMENT TO MEET THE NEEDS OF THE RESIDENT:

R86 was observed on 3/28/2016, at 4:52 p.m. R86 was observed to be missing one tooth on top left side of the mouth and one tooth missing on the bottom right side of his mouth.

R86's oral assessment dated 2/24/16, did not identify R86 had missing teeth or any dental concerns.

R86's care plan revised 12/9/15, did not identify R86 had missing teeth or any dental concerns.

On 3/31/2016, at 12:58 p.m. the director of nursing (DON) stated she reviewed the facility dental assessment and confirmed the assessment did not have an option to pick missing teeth for condition of natural teeth. The DON stated she expected staff to include missing teeth in the oral assessment and stated staff could indicate missing teeth under the comments section of the assessment. The DON stated she checked R86's oral assessments that had been completed by the facility and stated none of the assessments addressed R86's missing teeth. The DON stated there was nothing in the care plan for R86 that addressed missing teeth and stated R86's missing teeth should have been identified on the care plan.

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The Oral health policy with a review date of 1/16, instructed staff, "An oral health assessment will be done on admission, annually, quarterly and with a significant change in resident's condition by a registered nurse (RN)...Procedure:...condition of natural and artificial teeth..."
LACK OF IDENTIFICATION AND MONITORING OF BRUISING:

R68 was observed on 3/28/16, at 4:43 p.m., to have two dark purple bruises on top of his right hand and wrist area.

R68's quarterly Minimum Data Set dated 2/17/16, identified diagnosis of anemia.

R68's progress notes identified R68 had prior bruising of the right forearm on 6/28/16, and the left knee on 12/15/15.

R68's care plan was reviewed and did not include a problem area related to R68's risk for bruising, interventions to prevent bruising, nor interventions to implement if bruising was identified.

On 3/30/16, at 11:06 a.m., nursing assistant (NA)-H verified R68 had bruising on his right hand and wrist area. NA-H stated the facility system was the NAs usually report to the charge nurse when bruising is noted, then the charge nurse makes a report.

On 3/30/16, at 11:36 a.m., registered nurse (RN)-D verified R68 had two bruises located on his right hand and wrist area. RN-D stated we were not aware of the bruising. RN-D stated the nurse usually identified bruising during body audits on bath days or the NAs would report the

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bruising. Then a risk assessment would be completed, the size of the bruise would be documented and the bruising would be monitored until healed.

On 3/30/16, at 11:41 a.m., NA-I stated she had assisted R68 with getting dressed this a.m. NA-I stated, when queried if R68 had any skin concerns or bruising, R68 had very fragile skin, I put lotion on R68's arms and shoulders, I did not notice any skin concerns and R68 always has those bruises.

On 4/1/16, at 10:40 a.m., the DON stated the facility system was anytime a NA sees a bruise the NA notifies the nurse. The nurse then measures the bruise and enters the information into risk management. Then around 24 hours after discovery we work on an intervention to put into place and try to find out how the bruise occurred. The DON stated she would expect the bruising to be reported and would expect bruising to be identified on the care plan as a problem area, as R68 has had bruising before.

A policy for non-pressure skin conditions was requested, but not provided.

R61 was observed on 3/30/16, at 1:27 p.m., with RN-D to have an area at the end of R61's right great toe that was dried, hard and dark brown in color.

R61's quarterly Minimum Data Set dated 12/30/15, identified diagnosis of diabetes.

R61's care plan, revised on 1/15/16, identified R61 was at risk for skin issues related to history of pressure ulcers and venous ulcers,

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anticoagulant medication use, venous insufficiency, vascular disease, incontinence, decreased mobility and edema.

R61's progress notes identified the following:
3/18/16, incident: staff found what appears to be an old blood blister on resident's right great toe. Area does not appear to be pressure as resident does not wear shoes and does not sleep with feet covered with blankets. His toe may have been pinched when pushing his chair up to the table at meal time. Resident is unaware of what happened. Area measures 1.7 cm (centimeters) by 1.8 cm. Interventions: Apply alkare daily. Physician notification: fax prepared. However, R61's record failed to include documentation of the fax prepared.
3/20/16, follow up incident, type of incident: resident sustained blood blister injury possibly from his feet hitting the dinner table. He does not wear shoes. He is unable to state what happened. Blister area now appears hard and scabbed over. Area around toe appears healthy. No drainage or bleeding. Will continue to monitor. Dx (diagnosis) that may have contributed include type two diabetes. Rx (medication) that may have contributed include metoprolol (beta blocker) and novolog insulin.
3/20/16, blister is dark red/purple in color. Has yellow dry skin on top. No drainage.
3/24/16, blister right great toe, dry with dried blood under skin.
3/25/16, document on blister of right great toe, 2 cm x 1.2 cm area with dried blood under skin and hard callous center. No discomfort. No open area.

R61's physician progress note dated 3/24/16, per interview with the DON on 3/31/16, at 1:40 p.m.,

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identified extremity poor foot perfusion. However, R61's record failed to include documentation of notification of R61's physician regarding the change in condition of R61's right great toe which included a diagnosis and treatment orders.

On 3/30/16, at 1:27 p.m., RN-D stated she did not know if the area on R61's right great toe was a pressure area or not. RN-D stated she did not know if the area was measured weekly and she had completed the treatment yesterday and had not measured it. RN-D stated documentation for the treatment would be on the treatment administration record (TAR) and the TAR allowed for the nurse to make a progress note, which then would appear in R61's progress notes.

On 3/31/16, at 1:40 p.m., the DON verified R61's record lacked documentation of R61's physician being notified of the change in skin condition of the blister located on R61's right great toe.

The facility policy Change in Condition Notification, dated review date 1/16, indicated standards: attending provider or provider on call is to be notified of resident's change in condition/health status. Procedure: 1. Between reasonable business or typical wakeful hours, seven days a week, attending provider or provider on call is to be notified of all conditions or health status changes. 2. After hours, the attending provider or provider on call should be notified of any change in condition, health status or incident (list is not inclusive, examples only): Resulted in an injury having the potential for provider intervention .... 3. Document time of call, provider or other person spoken to, reason for call and results or orders received.
LACK OF FOLLOWING PHYSICIAN ORDERS

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IN THE TREATMENT FOR AN ACUTE HEALTH NEED:

R77's admission record, dated 1/22/16, indicated that the resident had diagnoses of: subsequent non-ST elevation (NSTEMI) myocardial infarction (heart attack), heart failure and hypertension.

R77's hospital discharge summary, dated 1/17/16, indicated that the resident had been admitted to the hospital for a heart attack. The report summarized that R77 had been having EKG changes and an elevated troponin.

R77's care plan, dated 1/23/16, indicated the resident was at risk for alteration in cardiovascular status. A Goal identified were that labs would remain within normal limits. It advised that R77 obtain lab tests as ordered.

R77's progress notes, dated 3/4/16, indicated that the resident had new physician orders which stated, "Give Lasix [a medication used to decreased the amount of fluid in a body] 40 mg po [by mouth] now. Change Lasix to 80 mg po BID [twice a day] at 0800 and 1200 starting 3/5/17. Recheck BNP [a lab test used to determine if heart failure develops or worsens], BMP [a routine blood panel test] on 3/9/16."

R77's blood chemistry report, dated 3/4/16, indicated that the resident had a BNP level of 2509. A normal reference range would be 10-263.

A copy of R77's physician orders, dated 3/4/16 was handwritten and signed by the attending physician. It ordered a BNP to be completed on 3/9/16.

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R77's progress notes, reviewed from 3/9/16 through 3/31/16, did not indicate that the BNP had been completed as ordered.

R77's blood chemistry report, dated 3/4/16 reviewed from 3/5/16 through 3/23/16, indicated that the BNP had not been done.

When interviewed on 3/31/16 at 10:34 a.m., registered nurse (RN)-I stated that the BNP had not been done on 3/9/16 as ordered. RN-I stated that the lab had not been done at all since 3/4/16. RN-I checked the computer system from the hospital and confirmed that the lab was not in the system.

When interviewed on 3/31/16 at 10:37 a.m., health unit coordinator (HUC)-D stated that the BNP had not been ordered; nor had it been done. HUC-D stated that once the physician ordered a lab, the HUC would then place it in the computer system; once this was done a nurse would check the order and confirm that it was in place. HUC-D stated that it had not been done in this case.

When interviewed on 4/1/16 at 12:58 p.m., the director of nursing (DON) stated that the staff should have followed the physician's orders and ordered the lab test to be performed.

Review of the facility policy titled, Provider Laboratory Orders (last reviewed 1/16) included: The lab values to be drawn on a resident per provider orders. It directed the HUC/nurse to transcribe an order with a due date in a lab book. A one-time order would be put in the lab book under "other." A HUC/nurse would fill out a lab slip when the lab was due. It then directed the notify the lab or the orders via inner mailing or

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F 309	Continued From page 36 phone.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete an assessment to determine if residents were safe to be left unattended in the whirlpool bathtub for 4 of 4 residents (R31, R7, R25 and R90) reviewed for accidents. Findings Include: R31's care plan dated 6/23/16 indicated R31 had made the determination to bathe (soak) unsupervised in a whirlpool bathtub and identified R31 had an awareness of the potential risks that included death; "I will be aware of risks and benefits such as slipping in the tub while unsupervised causing injury or death, My decision will be reviewed quarterly." R31's plan of care for cognition informed staff of "chronic decline in intellectual functioning" related to stroke that impaired memory, judgment, decision making, and thought processing; conflicted with R31's cognitive abilities indicated in the plan of care for unsupervised bathing. In addition, the care plan identified R31 to have a history of stroke that resulted in aphasia (inability to speak or	F 323	Careplans updated on R31, R7, R25, and R 90. Education added to precepting sheets for all new nursing staff. Education done with all Nursing Staff on the bathing process of ensuring all residents will not be left unattended in the whirl pool tub. Audit completed by Hall Nurse three times each week for 3 months. Results will be reviewed by QAPI team.	5/3/16

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F 323	Continued From page 37 understand language related to disease or brain injury) and paralysis of the right side of her body. The dressing/bathing/personal hygiene plan of care conflicted with the unsupervised bathing and directed staff to give "weekly tub bath with assist of 1." and informed staff, "resident needs extensive assistance related to: cognitive impairment, decreased physical functioning, and impaired mobility of lower extremities." R31's quarterly Minimum Data Set (MDS) dated 12/30/15 indicated the staff assessed R31 to have moderately impaired decision-making skills for daily living, identified R31 to have short and long-term memory problems, and required extensive physical assist from two staff members for transfers and bathing. The facility face sheet included diagnoses of stroke with one sided paralysis, diabetes type II, aphasia, blindness in one eye, major depressive disorder, heart failure, atrial fibrillation, arthropathy (inflammation of joints), and osteoporosis. R31's record did not reflect a comprehensive assessment to determine R31's physical and cognitive abilities to bathe (soak) in a tub unsupervised that identified the potential safety risks and interventions to decrease the risks R31's record did not reflect evidence of a completed analysis to determine risk level to bathe unsupervised based off the assessed predisposing factors identified on the MDS of impaired speech, understanding/judgment, and mobility. On 3/30/16, 8:35 a.m. registered nurse (RN)-B stated she did not think it was a good idea to leave R31 alone in the bath tub at this time and stated she did not think R31's care plan was current. RN-B stated R31 had a decline, stated she was not as alert, would slink over at times, was not eating well and was weaker. RN-B stated	F 323		

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F 323	Continued From page 38 there was no assessment completed to determine if R31 was safe to be in the whirlpool bathtub unsupervised. RN-B stated review of risk and benefits should be documented in the care conferences notes on a quarterly basis. On 3/30/2016, at 1:18 p.m. the DON stated R31 would not be able to communicate she would want to be left in the bathtub, as she was nonverbal and stated she was not sure how R31 was identified by the nursing assistants as an appropriate candidate to be left alone in the bathtub unsupervised. The DON stated there were no safety assessments completed to determine if the residents identified by the nursing assistants as wanting to soak longer in the bathtub alone unsupervised were safe to be alone in the bathtub, the decisions were just based on resident choice. (*Note: It is not within a nursing assistance scope of practice to perform assessments/evaluations for any resident care planning needs or determinations; assessments/evaluations can only be performed by a trained licensed staff member.) The DON stated if an assessment would have been done for safety, R31 would have never have been identified as a resident that could be left unsupervised in the bathtub. The DON stated R31 would not be safe to be left alone in the bathtub unsupervised and confirmed the care plan indicated staff could leave R31 unsupervised in the whirlpool bathtub. The DON stated staff were supposed to review risk and benefits on a quarterly basis at care conferences with residents or family members. The DON stated she was aware there was no documentation in the progress notes to indicate the risk or benefits were reviewed at the quarterly care conferences for R31. The DON stated, "On a positive note at least you were the one to find this and we did not	F 323		

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F 323	Continued From page 39	F 323		

have a resident drown."
An environmental concern was also identified with the call light placement in the whirlpool tub rooms. On 4/1/16, at 9:20 a.m. the DON stated the call light cords in both whirlpool tub rooms were not long enough for residents' to use in either tub room and the facility needed to do something else for a call light and stated they were looking at getting a longer cord. The DON verified there was no way to fasten the cord to the tub for resident access and use.

R7's care plan with a revision date of 5/3/15, indicated R7 had made the determination to bathe (soak) unsupervised in a whirlpool bathtub and identified R7 had an awareness of the potential risk: "Risk and Benefit for ...choosing to stay in bathtub with staff not in attendance. Goal: I will be aware of risks and benefits and my decision will be reviewed quarterly." R7's plan of care for cognition informed staff of "cognitive loss" related to short term memory loss, difficulty remembering, unable to reason, make decisions, unable to communicate needs effectively and need assistance with daily decisions related to history of stroke, conflicted with R31's cognitive abilities indicated in the plan of care for unsupervised bathing. In addition, the care plan identified R7 to have a history of stroke that resulted in aphasia (inability to speak or understand language related to disease or brain injury) and paralysis of the right side of her body. The dressing/bathing/personal hygiene plan of care conflicted with the unsupervised bathing and directed staff to give "weekly tub bath with extensive assist of 1."
R7's annual Minimum Data Set (MDS) dated 12/28/15, identified R7 to have brief interview for mental status score of two that indicated severe

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F 323	Continued From page 40 cognitive impairment, unclear speech, and required extensive physical assist from two staff members for transfers and bathing. The facility face sheet included diagnoses of stroke with one sided paralysis, aphasia, Alzheimer's disease, dementia with behaviors, and anxiety. R7's record did not reflect a comprehensive assessment to determine R7's physical and cognitive abilities to bathe (soak) in a tub unsupervised that identified the potential safety risks and interventions to decrease the risks. R7's record did not reflect evidence of a completed analysis to determine risk level to bathe unsupervised based off the assessed predisposing factors identified on the MDS of impaired speech, mobility and severe cognitive impairment. On 3/30/2016, at 1:18 p.m. the director of nursing stated there was not a safety assessment completed to determine if R7 was safe to be left unattended in the whirlpool bathtub. The DON stated if an assessment would have been done for safety, R7 would not have been identified as a resident that could be left unsupervised in the whirlpool bathtub. The DON stated R7 would not be safe to be left alone in the bathtub unsupervised and confirmed the care plan indicated staff could leave R7 unsupervised in the bath tub. The DON stated staff were supposed to review risk and benefits on a quarterly basis at care conferences with resident or family members. The DON stated when reviewing this particular risk and benefit form at care conference the facility was reviewing resident choice to be left unattended in the whirlpool bathtub, not resident's safety to be left unattended. The DON stated there should have been criteria in place to determine which residents would be appropriate to have a	F 323		

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F 323	Continued From page 41 comprehensive assessment completed to determine if a resident was safe to be left unattended in the whirlpool bathtub. The DON stated R7 should have never been asked if she wanted to be left alone to soak in the whirlpool unattended because of her current physical condition since having the stroke. R25's Risks and Benefits dated 5/13/15, indicated R25 had made the determination to bathe (soak) unsupervised in a whirlpool bathtub and identified R25 had an awareness of the potential risk that included death. R25's plan of care for cognition informed staff of periods of intermittent confusion and diagnoses of dementia. The dressing/bathing/personal hygiene plan of care conflicted with the unsupervised bathing and directed staff to give " limited assist with bathing." The mobility care plan informed staff, R25 needed extensive assist with a gait belt for transfers and indicated R25's transfers fluctuated related to back pain. R25's care plan did not address the risk and benefits that were completed to allow R25 to be left unattended in the whirlpool bathtub. R25's quarterly Minimum Data Set (MDS) dated 2/23/16, identified R25 required extensive assist of one staff for transfers, total dependence for bathing of one person physical assist, and a brief interview for mental status score of 6, which indicated severe cognitive impairment. The facility face sheet included diagnoses of transient ischemic attack (TIA-strokes), major depressive disorder, and osteoporosis. R25's record did not reflect a comprehensive assessment to determine R25's physical and cognitive abilities to bathe (soak) in a tub unsupervised that identified the potential safety risks and interventions to decrease the risks.	F 323		

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F 323	Continued From page 42 R25's record did not reflect evidence of a completed analysis to determine risk level to bathe unsupervised based off the assessed predisposing factors identified on the MDS of impaired mobility and severe cognitive impairment. On 3/30/2016, at 1:38 p.m. the director of nursing (DON) stated there was not a safety assessment completed to determine if R25 was safe to be left unattended in the whirlpool bathtub. The DON stated R25 had dementia, had attempted self-transfers and should not be left alone in the whirlpool bathtub unsupervised. The DON stated R25 should not have been asked if she would like to be left unsupervised in the in the whirlpool bathtub. R90's risks and benefits dated 5/13/15, indicated R90 had made the determination to bathe (soak) unsupervised in a whirlpool bathtub and identified R90 had an awareness of the potential risk that included death. R90's plan of care for cognition informed staff of cognitive loss related to, "difficulty remembering, unable to reason, make decisions at times r/t [related to] compounded by medical problems, forgetfulness."The dressing/bathing/personal hygiene plan of care conflicted with the unsupervised bathing and directed staff to R90 was, "unable to groom/bathe/dress self independently and need extensive assistance related to Dementia." The mobility care plan informed staff, R90 needed extensive from staff for transfers. R90's care plan did not address the risk and benefits that were completed to allow R90 to be left unattended in the whirlpool bathtub. R90's significant change Minimum Data Set (MDS) dated 2/1/16, identified R90 had a brief interview for mental status score of 7, which	F 323		

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F 323	Continued From page 43 indicated severe cognitive impairment, required extensive assist of two staff for transfers, assist of one for bathing, The facility face sheet included diagnoses of heart failure, and mild cognitive impairment. R90's record did not reflect a comprehensive assessment to determine R90's physical and cognitive abilities to bathe (soak) in a tub unsupervised that identified the potential safety risks and interventions to decrease the risks. R90's record did not reflect evidence of a completed analysis to determine risk level to bathe unsupervised based off the assessed predisposing factors identified on the MDS of impaired mobility and severe cognitive impairment. On 3/30/2016, at 1:05 p.m. nursing assistant (NA)-F stated R90 liked to soak in the bathtub and stated she had left R90 unattended in the whirlpool bathtub to make her bed and come right back or had left her to pick out her clothing and come right back. NA-F stated I would not leave her alone for very long, no longer than 5 minutes, because something can happen so fast. On 3/30/2016, at 1:38 p.m. the director of nursing (DON) stated there was not a safety assessment completed to determine if R90 was safe to be left unattended in the whirlpool bathtub. The DON stated she did not have any concerns with R90 being left alone in the whirlpool bathtub unsupervised and stated R90 did have dementia and an assessment should have been completed to determine if R90 was safe to be left unattended in the whirlpool bathtub. The DON stated there were no parameters put into place for how long staff could leave a resident alone in the whirlpool bathtub.	F 323		

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F 323	Continued From page 44 A policy was requested in regards to resident safety and none provided.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly discard a tuberculin solution in a timely manner which resulted in the administration of expired tuberculin for 1 of 1 resident(R127) reviewed. Findings include: R127's admission date was 3/29/16 according to	F 425	All tubersol supply has been checked for expiration dates. When tubersol is opened, sticker to state date opened and date expired to be placed at time of opening. Performance discussion completed with nurse on checking for expiration date of tuberculin solution. Nurses to be educated on checking for	5/3/16

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F 425	Continued From page 45 the admission form. R127's physician orders, dated 3/29/16, indicated that the resident had an order for Tubersol Solution (Tuberculin PPD). Staff were to inject 0.1 ml (milliliters) intradermally on admission for step 1 of a 2 step Mantoux using purified protein derivative. R127's medication administration record (MAR), dated 3/29/16, indicated that the resident received the ordered Tubersol solution. R127's medication administration note, dated 3/29/16, indicated that the resident received the Tubersol Solution. It stated that the vial had a lot number of C4864AA and an expiration date of 1/12/2018. It was administered in the right forearm. However, this vial of Tubersol had been opened on 2/23/16 and is not to be used after 30 days or by 3/24/16. When interviewed on 4/1/16 at 9:30 a.m., registered nurse (RN)-C stated that only one resident had been administered the tuberculin solution after 3/24/16 on the Country view unit (R127). RN-C stated that the staff should have checked the opened date of the vial of Tubersol solution every time that a vial would be used. When interviewed on 4/1/16 at 12:47 p.m., the director of nursing (DON) stated that the staff should not give expired tuberculin solution to anyone. The DON stated that the vial of tuberculin solution should have been discarded once it had reached its expiration after it had been opened. Review of the package insert for Tuberculin	F 425	expiration dates for all medications. Tuberculin solution expires 30 days from date of opening which is written on tuberculin solution. Nursing educated to place sticker on at time of opening with date opened and date expired. Audits to be completed by Night Charge nurse one time weekly for 3 months. Results will be reviewed by QAPI team.	

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F 425	Continued From page 46 Purified Protein Derivative (Mantoux) Tubersol solution (no date), directed that a vial of Tubersol which had been in use for thirty days should be discarded. Policy provided by facility lacked outdate information for Tubersol.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		5/3/16

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F 431	Continued From page 47 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled according to physician's orders for 3 of 25 medications reviewed during medication administration. This affected 3 of 8 residents (R7, R72, R107). Findings include: R7 was observed during a medication administration on 3/28/16 at 6:37 p.m., registered nurse (RN)-F administered one ribbon of lubricant eye ointment in each eye of R7. The label on the medication instructed staff to administer twice daily to the right eye only. R7's admission record, dated 2/26/20014, indicated that the resident had a diagnosis of a cataract. R7's physician orders, dated 2/17/16, instructed that the resident was to receive lubricant eye ointment 1 ribbon in each eye at bedtime. When interviewed on 3/28/16 at 6:42 p.m., RN-F stated that the label on the lubricant eye ointment was incorrect. RN-F stated that the correct procedure when an order had changed by the physician was to put a "change of directions" sticker on the medication which indicated that the order had changed. That would notify the nursing	F 431	Medications for R7, R72, and R107 have been checked for proper labeling and use of change in direction stickers applied. All medications have been checked to assure they are labeled according to physician orders or a change in direction sticker has been applied. Nursing staff to be educated on the policy of Medication Administration, which includes monitoring all meds for accurate dispensing labels. Consultant Pharmacy Nurse and Nurse Manager will complete weekly audits on medication carts for three months. Results will be reviewed by QAPI team.	

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F 431	Continued From page 48 staff to look at the actual physician's order. R72 was observed during a medication administration on 3/30/16 at 1:41 p.m., RN-J administered 0.5 mg (milligrams) of Ativan (an antianxiety medication) to R72. The label on the medication instructed to administer Ativan 0.5 mg four times a day and as needed 1/2 hour prior to treatment. R72's admission record, dated 12/11/13, indicated that the resident had a diagnosis of generalized anxiety disorder. R72's physician orders, dated 12/17/15, indicated that the resident was to receive Ativan 0.5 mg four times a day. R72's medication administration record, reviewed from 3/1/16 through 3/31/16, indicated that the resident had received Ativan as prescribed by the physician. When interviewed on 3/30/16 at 3:32 p.m., licensed practical nurse (LPN)-D stated that the label on R72's Ativan medication was incorrect. LPN-D stated that there should have had a "change of direction" sticker placed on the medication packet to indicate to the nursing staff that the orders had changed. LPN-D stated that when an order was changed, the pharmacy was also notified so when a new prescription was sent it would have the correct order written on it. R107 was observed during a medication administration on 3/31/16 at 7:15 a.m., RN-H administered 1000 mg of Tylenol to R107. The label on the medication instructed that R107 was to receive 1000 mg twice a day and every 6 hours	F 431		

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F 431	Continued From page 49	F 431		

as needed for pain greater than 5 on a 0 to 10 scale with 10 being the most excruciating.

R107's admission record, dated 10/15/15, indicated the resident had a diagnosis of a fracture of the first thoracic vertebra.

R107's physician orders, dated 10/20/15, indicated that the resident had an order for Tylenol.

R107's medication administration record, reviewed from 3/1/16 through 3/31/16, indicated that the resident received Tylenol 1000 mg by mouth two times a day for pain.

When interviewed on 3/31/16 at 8:35 a.m., RN-H stated that the label on the Tylenol for R107 was incorrect. RN-H stated that the medication packet needed a "change of direction" sticker affixed to it in order to indicate to the nursing staff the order was different from what was written on the medication package. RN-H then did place a "change of direction" sticker on the medication.

When interviewed on 4/1/16 at 12:45 p.m., the director of nursing (DON) stated that the staff should have placed "change of direction" stickers on the medications to indicate that there was a differing order from the instructions on the package. The DON stated that the pharmacy should be notified in order to get the instructions changed on future medication orders.

Review of the policy titled, "Administering Medication (1/16)," it instructed that the nurse was responsible for checking to see the drug and dosage schedule on the resident's medication administration record (MAR) matched the label

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F 431	Continued From page 50 on the medication container. If the medication container was marked with a label which indicated a recent change in the directions for the use of the medication or there was any reason to question the dosage or the dosage interval, the nurse was to check the provider's orders for clarifications.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		5/3/16

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F 441	Continued From page 51 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices for catheter and perineal cares for 1 of 3 residents (R68) reviewed for urinary catheter; failed to ensure surveillance and analysis of infections. This had the potential to affect all residents, staff, and visitors. In addition, the facility failed to properly administer eye drops for 1 of 1 residents (R7) who received eye drop medication. Findings include: CATHETER AND PERINEAL CARES: On 3/31/16, at 7:27 a.m., nursing assistant (NA)-G washed hands, donned gloves and changed a catheter drainage bag to a catheter leg bag for R68. NA-G then with the same soiled gloves on applied R68's stockings, secured R68's catheter tubing to R68's left thigh with a strap, opened the bathroom door, drained the urine out of R68's catheter drainage bag into the toilet, opened R68 room door to ask a staff person for a clean syringe/container (to be used to clean R68's catheter drainage bag) and removed gloves. Immediately following this observation NA-G, without washing hands placed R68's	F 441	Policies were reviewed on Perineal care and Catheter care. Nursing staff will be re-educated to infection control practices to include perineal care and catheter care. Audits will be completed two times each week by Infection Control Nurse and Nurse Managers for three months. Results will be reviewed by QAPI team. Nursing staff will be re-educated to appropriate infection control practices with the administration of eye drops and ointments. Audits by Consultant Pharmacy nurse and Nurse Managers will be done one time a week for 3 months. Results will be reviewed by QAPI team. Facility infection control program will be reviewed and revised as indicated. Infection Control Nurse was educated to document surveillance and analysis of infections. Education nurse updated her spread sheet of infections to include analysis and implemented a map to document surveillance. Audit to be completed weekly by DON or designee for three months. Results will	

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F 441	Continued From page 52 catheter drainage bag inside of a garbage can located in the bathroom. NA-G then placed the dirty gloves she had removed on top of the catheter bag, which was laid in the garbage can. NA-G then applied R68's shoes and walked R68 into the bathroom. NA-G then donned clean gloves, removed R68's incontinent product, which NA-G stated had bowel movement on the pad. NA-G placed the soiled incontinent product on top of R68's catheter bag laid in the garbage can. NA-G then with the soiled gloves grabbed a wash basin out of R68's room from a cupboard, placed the basin into the bathroom sink, opened R68's closet and obtained a clean incontinent product and assisted R68 with putting on the clean incontinent product. NA-G then with the same gloves on obtained R68's clothes, assisted R68 to remove his pajamas and handed R68 a washcloth to wash his face. NA-G then with the same soiled gloves on cleansed around R68's perineal catheter site and laid the washrag used to cleanse the perineal catheter site on top of R68's catheter drainage bag laid in the garbage can. NA-G then with the same soiled gloves on picked up a sterile bottle of normal saline and the clean syringe/container and placed them back down. NA-G then removed the soiled gloves, placed the dirty gloves and used syringe/container into the garbage can on top pf R68's catheter drainage bag. NA-G then opened R68's room door, walked out of R68's room into the hallway and obtained a clean a clean wash cloth and towel from the linen cart. NA-G then walked back into R68's room and washed hands with hand sanitizer. NA-G failed to remove gloves and wash hands after removing a soiled incontinent product and after providing perineal cares.	F 441	be reviewed by QAPI team.	

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F 441	Continued From page 53 NA-G continued to provide R68 with cares and was observed to donn clean gloves, assisted R68 to stand and washed R68's buttocks with a wash cloth. NA-G then with the same soiled gloves on pulled up R68' pants and assisted R68 to walk back to bedside and sit down on R68's bed. NA-G then removed gloves, emptied out R68's wash basin, dried the wash basin out with a paper towel and disposed of the paper towel into the garbage can on top of R68's catheter drainage bag. NA-G failed to remove gloves and wash hands after cleansing R68's buttocks. NA-G then without washing hands, donned clean gloves and obtained R68's toothbrush, toothpaste and proceeded to brush R68's dentures. NA-G then with the same gloves on removed R68's soiled incontinent product and soiled wash cloth from the garbage, and placed the items in separate plastic bags. NA-G then with the same gloves on removed R68's catheter drainage bag from the garbage can and proceed to rinse the catheter drainage bag out two times using the clean syringe and container NA-G had filled with normal saline. NA-G then placed the catheter bag into a plastic bag and then put the bag containing the catheter bag into R68's night stand drawer. NA-G then removed gloves, opened the privacy curtain and washed hands. NA-G filed to remove gloves and wash hands after cleansing a urinary catheter bag and failed to ensure R68's had a clean catheter drainage bag after having placed the catheter drainage bag into a garbage can. On 3/31/16, at 7:52 a.m., NA-G was interviewed about the observations made during the cares R68 had just received from NA-G. NA-G agreed that she had not removed soiled gloves or wash hands to prevent infection. NA-G, when queried regarding if R68 had any current infections	F 441		

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F 441	Continued From page 54 replied, "Yeah, he has MRSA [Methicillin-resistant Staphylococcus aureus] in his urine." R68's medication administration record, dated 3/16, identified R68 was receiving Bactrim (antibiotic) DS (double strength) 800-160 mg (milligrams) one tablet two times a day for infection for 10 days. R68's progress note, dated 3/26/16, identified new order: Bactrim DS one two times daily for 10 days and the reason was for urinary tract infection, MRSA. On 3/31/16, at 1:22 p.m., registered nurse (RN)-C verified R68 was being treated with an antibiotic and had MRSA infection. RN-C stated she would expect gloves to be removed and hands washed after changing catheter bags, after cleansing around the perineal catheter site and after cleansing buttocks. RN-C stated she would want a new catheter bag to replace the catheter bag that had been laid in the garbage can. On 3/31/16, at 1:49 p.m., the director of nursing (DON) stated she would expect gloves to be removed right away and hands to be washed before touching other items after changing catheter bags, after cleaning the perineal catheter site, after cleansing buttocks and after changing a soiled incontinent product. The DON stated she would expect staff not to place the catheter drainage bag in the garbage can during use. The facility policy Care of Urinary Drainage and Leg Bags, dated 1/16, indicated procedure: 11. Connect tubing of drainage bag or leg bag to catheter. 12. Store leg/drainage bag in Ziploc bag in bedside stand when not in use after rinsing with sterile water. 13. Remove gloves and wash hands.	F 441		

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F 441	Continued From page 55	F 441		

The facility policy Foley Catheter Care, dated 1/16, indicated procedure: 7. Cleanse perineal area with soap and water. 10. Dry perineal area. 11. Anchor catheter to thigh with catheter strap. Remove gloves and wash hands.

The facility policy Hand Washing, dated 3/16, indicated proper hand washing is the best way to prevent spread of disease. It protects both the employee and the resident. Procedure: 1. Hand Washing is done: b. After handling contaminated equipment, dressings, soiled linen, etc. g. after removal of gloves.

LACK OF A FUNCTIONING INFECTION PROGRAM WHICH INCLUDES SURVEILLANCE AND ANALYSIS:

The facility Monthly Infection Prevention and Control Reports were obtained from 4/2015 through 2/2016. The following information of infections were indicated on the monthly reports:
4/15, seven urinary tract infections (UTI's), four respiratory, two skin
5/15, four UTI's, five respiratory, two skin
6/15, five UTI's, three respiratory, three skin
7/15, four UTI's, three respiratory, one skin
8/15, four UTI's, six respiratory, two skin, one other
9/15, eight UTI's, three respiratory, three skin, one other
10/15, five UTI's, two respiratory, three skin
11/15, five UTI's, one respiratory, three skin
12/15, four UTI's, one respiratory
1/16, five UTI's, four respiratory, one skin
2/16, six UTI's, two respiratory, two skin

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F 441	Continued From page 56 The facility failed to document surveillance and analysis of the information and infection control precautions used to prevent the spread of the infection. On 3/31/16, at 1:04 p.m., RN-C stated she had no documentation of surveillance and analysis of the above information. RN-C stated we talk about hand hygiene and peri-cares during stand up, nurses and nursing assistant meetings and increased audits on nursing assistants providing peri-cares. The facility policy Infection Prevention and Control Program, undated, indicated I. The Infection Prevention Committee (IPC) is charged with overseeing the infection prevention program. This committee is responsible to the corporate and facility wide Quality Assurance Committee. The IPC carries the responsibility of surveillance, prevention, control and reporting of infection within the facility. The IPC provides program oversight, review and provides guidance of the infection control program, ensuring the facility's compliance to quality infection prevention standards. III. Infection Preventionist (IP), each facility shall designate an RN, to coordinate the process of the infection prevention program. The IP responsibilities include: 9. Managing surveillance of data (gathering, analysis and reporting processes). IV. Surveillance, The infection control surveillance is the process of data collection on nosocomial infection within the facility, as means for early detection of outbreaks. The surveillance data is additionally used to plan control activities and educational programs. A. The process 2. Recording, review, analysis and reporting of the case data is done monthly, quarterly and annually to detect trends.	F 441		

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Educational and control efforts are assisted by this data.
LACK OF EYE MEDICAITON ADMINISTRATION TO PREVENT INFECTIONS:

R7's admission record, dated 2/26/04, indicated the resident had a diagnosis of a cataract.

R7's physician orders, dated 7/1/05, indicated the resident received artificial tear solution: 2 drops in both eyes two times a day related to dry eyes. The physician orders, dated 2/17/16, indicated that R7 received lubricant eye ointment: 1 ribbon was to be instilled in both eyes at bedtime related to cataracts.

During an observation of a medication administration on 3/28/16 at 6:37 p.m., registered nurse (RN)-F prepared the medications for R7. RN-F knocked on R7's door, entered and explained the procedure to R7. RN-F put on a pair of gloves and explained that R7 was to receive eye drops. RN-F took the bottle of artificial tears, and with one gloved hand, lowered the lower eyelid of the right eye. RN-F then touched the tip of the bottle of artificial tears to the sclera [the white outer layer] of the eyeball and administered one drop of artificial tears to the right eye. RN-F repeated this process with R7's left eye. RN-F did touch the sclera of R7's left eye as well. RN-F then prepared to administer lubricant eye ointment from a tube and explained the procedure to R7. With a gloved finger, RN-F lowered the lower eyelid of R7's right eye and administered a ribbon of ointment underneath the lower eyelid. RN-F again touched the tip of the tube where the medication was applied. RN-F repeated this process to the left eye. In the process, the tip of the tube of eye lubricant again

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F 441	Continued From page 58 touched underneath the lower left eyelid. When interviewed on 3/28/16 at 6:42 p.m., RN-F stated that he might have touched underneath the lower lid of the left eye with the tip of the tube of eye lubricant. When interviewed on 3/30/16 at 11:00 a.m., RN-J stated when administering eye medications, the nurse should never touch the eyeball with the tip of the container. RN-J stated that if a resident were to have an infection (such as pinkeye) in one eye, the infection would spread from one eye to the other. When interviewed on 4/1/16, at 12:43 p.m., the director of nursing (DON) stated that the nurse who administered the eye drops as well as the eye lubricant should not have touched the eye with the tip of the medication containers. Review of the document titled, "Administering Eye Medications (1/16)," it explained the proper procedure for administering eye medications. It stated, "Avoid touching the dropper against the eye or anything else."	F 441		

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FORM APPROVED
OMB NO. 0938-0391

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

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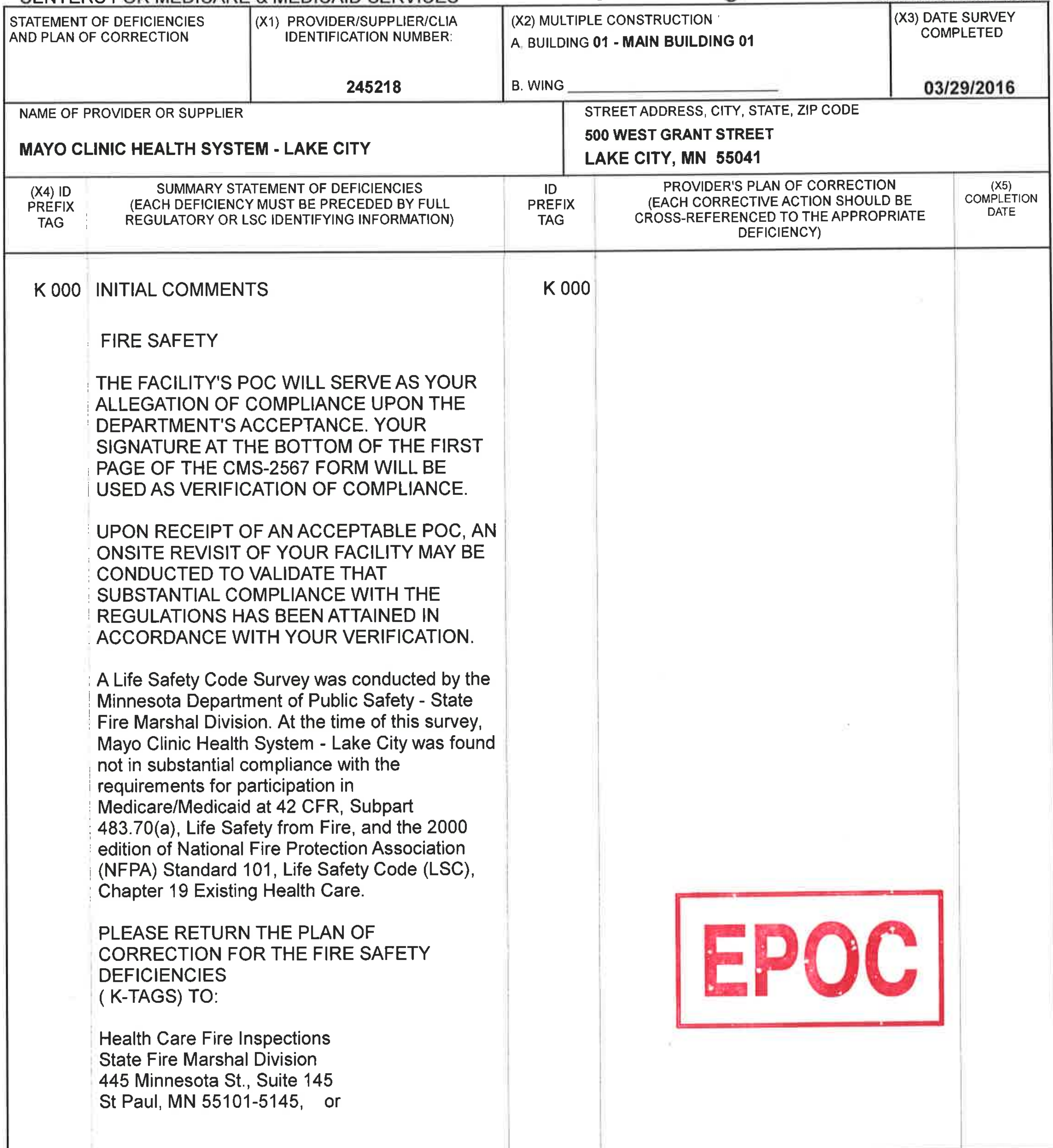

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Mayo Clinic Health System - Lake City was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/21/2016

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Mayo Clinic Health System - Lake City was original built in 1977. The facility it is a 1-story building and was determined to be of Type 1 (332) construction. In January 2003, the chapel addition was built and was determined to be of Type I (332) construction. There is no basement in either buildings. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed has one building. .

The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 90 beds and had a census of 83 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: K-154: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:#0 AM and 12:30 PM on 03/29/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 154	A single plan for the out of service plan for the fire sprinkler was created and put in place.	5/3/16
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: K-155: Where a required fire alarm system is out	K 155	K155 A single plan for the out of service	5/3/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 155	Continued From page 3 of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:30 AM and 12:30 PM on 03/29/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 155	plan for the fire alarm system was created and put in place.	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
April 13, 2016

Mr. Jacob Suckow, Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5218025

Dear Mr. Suckow:

The above facility was surveyed on March 28, 2016 through April 1, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ________ B. WING ________	04/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

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

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

Electronically Signed — 04/21/16

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 28, 29, 30, 31, and April 1, 2016 surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a plan of care for 1 of 1 resident (R111) reviewed for dental services.	2 560	corrected	5/3/16

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2 560	Continued From page 2	2 560		

Findings include:

R111's admission record indicated the resident was admitted to the facility on 11/18/15.

R111's admission Minimum Data Set (MDS), dated 11/24/15, indicated that the resident had no dental issues. R111 needed extensive assistance by one staff member with personal hygiene. R111's quarterly MDS did not indicate whether the resident had any problems with her teeth. It specified that R111 needed extensive assistance by two staff members with personal hygiene.

R111's care plan, dated 11/18/15, indicated that the resident was unable to groom herself independently and needed extensive assistance related to her dementia.

R111's kardex report (used to instruct nursing assistants on cares for each resident), dated 11/18/15, did not contain any information in regards to oral care.

R111's oral exam, dated 2/22/16, stated that the resident had artificial teeth which were worn most of the time. The resident was observed to have food particles or tartar in two spots on her artificial teeth.

R111's nutritional assessment, dated 2/26/16, stated that the resident had a chewing and dentition problem.

During an observation on 3/29/16 at 9:29 a.m., R111 was observed to have two missing teeth on her lower palate.

During an observation of cares on 3/31/16 at 7:37 a.m., nursing assistant (NA)-H assisted the

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2 560	Continued From page 3	2 560		

resident with dressing. NA-H did not perform oral hygiene at this time.

When interviewed on 3/31/16 at 8:16 a.m. nursing assistant (NA)-H stated that R111 had dentures. NA-H described the resident as having a full plate of dentures on the top and a partial set of dentures on the bottom. NA-H stated that the resident had not been leaving them in. Currently, the dentures were placed in a cup in R111's room. NA-H stated that she put a denture tablet in the cup with water to clean the dentures at night. NA-H stated that after breakfast, she would clean the resident's remaining teeth with a pink swab. NA-H stated that she would do this after meals.

During an observation on 3/31/16 at 9:44 a.m. with licensed practical nurse (LPN)-B, R111's oral cavity was assessed. The resident's dentures were currently in a cup of water. The resident had a few teeth remaining on her bottom palate. LPN-B stated that R111 did not keep her dentures in her mouth.

When interviewed on 3/31/16 at 9:54 a.m., licensed practical nurse (LPN)-B stated that the nursing assistants perform oral cares for R111 by brushing her teeth with a tooth brush. LPN-B stated that the staff should be performing oral cares twice a day. LPN-B stated that it depended on the resident if she allowed the staff to use a toothbrush; LPN-B stated that if the resident started striking out then they staff would attempt to use oral swabs to complete oral cares. LPN-B stated that the resident had struck out at staff in the past. LPN-B stated that specific oral cares for R111 should have probably been care planned.

When interviewed on 3/31/16 at 10:45 a.m., nursing assistant (NA)-K stated that R111 had

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2 560	Continued From page 4	2 560		

dentures. R111 would have her dentures cleaned in the morning and evening. NA-K described using mouthwash prior to cleaning R111's mouth with pink oral swabs. NA-K stated that she would wait after R111 had eaten a meal in the morning to perform oral cares. NA-K stated that she would first explain to R111 what she was about to do when performing oral cares in order to avoid having the resident potentially strike out at her.

When interviewed on 4/1/16 at 10:18 a.m., nursing assistant (NA)-J stated that she would make sure that R111's dentures were brushed. NA-J would swab R111's mouth with a pink swab. NA-J stated that she would do that every shift while she worked with R111. NA-J stated that she was afraid to use a toothbrush with R111 as the resident would bite down and not give it back. NA-J stated that when the resident was first admitted to the facility, she would let the staff use a toothbrush when cleaning her teeth; now, NA-J described that R111 would only bite down on a toothbrush and not let the staff clean her teeth.

When interviewed on 4/1/16 at 12:54 p.m., the director of nursing (DON) stated that R111 should have had an individualized care plan regarding her oral hygiene. The DON stated that the information would have been put in the Kardex so the nursing assistants would know how to care for R111 as well.

The facility Care Plan Policy, review date 1/16, indicated V. [five] concerns and problems B. Sources are, but not limited to: 8. Problems related to preventive care. 11. All problems requiring care. VII. [seven] Approach/Plan C. Individualized care for the unique needs of the resident. H. List preventive measures. IX. [nine] Review Date B. The care plan must be reviewed

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2 560	Continued From page 5 and revised (updated) as necessary. XII. [12] Resident Care Plan Documentation and Use of the Plan C. The resident care plan is used to plan and assign care for all disciplines. E. The resident care plan must be kept current at all times. F. Develop procedures to communicate all care plan information to the resident care staff. Suggested method of correction: The director of nursing (or designee) could review policies/procedures and update if needed, provide and/or reinforce education to staff members. Then the facility could perform routine audits to ensure staff are following care plans as part of their quality assurance program to maintain compliance. Time period of Correction: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan related to diet orders for 1 of 3 residents (R85) reviewed for nutrition and the facility failed to follow the care plan to observe skin with daily cares for 1 of 3 residents (R86) observed to have bruises, reviewed for non pressure related skin conditions.	2 565	Corrected	5/3/16

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2 565	Continued From page 6	2 565		

Findings include:

LACK OF FOLLOWING CARE PLANNED DIET:

R85's care plan, print date 3/31/16, identified R85 has a risk for fluid/electrolyte imbalance related to poor intake, nectar restriction with interventions of discontinue from speech therapy services, on mechanical soft textures and nectar thick consistency, okay for free water between meals. R85 is at risk for inadequate intake related to significant weight loss noted since admission, decreased appetite and intake with interventions of high kcal, high protein kcal, with nectar liquids.

R85's physician orders, dated 3/7/16, identified an order for high protein, high calorie diet, mechanical soft texture and patient okay for free water protocol, thin water between meals.

On 3/30/16, at 12:02 p.m., R85 was observed sitting in a wheelchair at a dining room table for the noon meal. R85 had a 240 cc (cubic centimeters) of regular water, 240 cc of nectar thick orange drink and 120 cc of nectar thick ensure chocolate drink, a small bowl of cottage cheese with two peaches on top, hamburger chowder, a piece of iced oatmeal cake and a slice of bread. R85 was observed to eat independently. Nursing assistant (NA)-G was observed to be sitting at the same dining room table assisting another resident with eating and was encouraging R85 to eat during the meal. R85's dietary sheet of paper on the table next to R85's food, indicated diet: high protein, high calorie, mechanical soft, liquid nectar thick.

On 3/30/16, at 12:25 p.m., registered nurse (RN)-D verified R85 had regular water.

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2 565		2 565		

Continued From page 7

On 3/30/16, at 12:27 p.m., dietary manager (DM)-B looked at R85's dietary sheet on the table and stated R85 should not have thin [regular] water at meal time. DM-B then removed the full glass (240 cc) of regular water from the table. DM-B stated R85 was able to have regular water 30 minutes before or after meals and in R85's room between meals. DM-B stated R85 was to have nectar thickened liquids during meals. DM-B stated the staff should have removed the water from the table when R85 was served her meal.

On 3/31/16, at 9:44 a.m., the DM-B stated the dietary sheets were part of the residents care plan.

On 3/31/16, at 1:42 p.m., the director of nursing (DON) stated that would be wrong for R85 to have regular water at meal time and R85 should have regular water between meals if that is what R85's care plan and physician orders indicate.

LACK OF MONITORING SKIN STATUS PER CARE PLAN:
R86's plan of care dated 10/1014 instructed staff to, "monitor my skin with cares and with weekly bath."

R86 was observed on 3/28/16, at 4:49 p.m. to have a bruises on the top of his right and left hands and right and left forearms with no documentation of these being identified by the staff.

However, there was documentation of bruising after the surveyor brought these bruises to the attention of the staff on 3/31/16. The progress note dated 3/31/16 indicated, "New Bruise or Follow up: Bruising found on resident left forearm measuring 2 x 1.2 cm [centimeters], 1 x 1.5 cm 3

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2 565	Continued From page 8	2 565		

x 2.4 cm, bruising also found on right elbow 19 x 2 cm, 4 x 8 cm and 3 x 1.5 cm. Information on Bruise: Bruising purple to light purple in color, resident denies any pain." Following this progress note was another progress note dated 3/31/16 which said, "New Bruise or Follow up: Bruises also found on left hand 1 x 1 cm [centimeters], 8 x 7 cm, 3 x 2 cm, right hand 14 x 8 cm."

On 3/31/2016, at 10:25 a.m. nursing assistant (NA)-C stated residents' skin was monitored for bruises on their bath days when a complete skin assessment was completed by a nurse. NA-C also stated if we see any new concerns with bruising during daily cares, when we are washing them up in the morning, we alert the nurse. NA-C stated she was unaware of any bruising on R86 at this time.

On 03/31/2016, at 12:51 p.m. the director of nursing (DON) stated there was no documentation in the medical record regarding the bruising on R86's arms or hands. The DON stated she expected staff to document and monitor bruises for healing. The DON stated on bath days a full skin assessment was completed by the nurse. The DON stated nursing assistants should be looking at skin during morning and evening cares and notify the nurse of any bruising. The DON stated residents' skin should be looked on a daily basis. The DON stated the care plan instructed staff to, " monitor my skin with cares and with weekly bath" and confirmed the staff did not follow the plan of care to identify R86's bruising.

The facility Care Plan Policy, review date 1/16, indicated V. [five] concerns and problems B. Sources are, but not limited to: 8. Problems related to preventive care. 11. All problems

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2 565	Continued From page 9 requiring care. VII. [seven] Approach/Plan C. Individualized care for the unique needs of the resident. H. List preventive measures. XII. [12] Resident Care Plan Documentation and Use of the Plan C. The resident care plan is used to plan and assign care for all disciplines. F. Develop procedures to communicate all care plan information to the resident care staff. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible to carry out the resident's comprehensive care plan to provide services and treatments as directed in the comprehensive care plan. Then to monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 570	Corrected	5/3/16

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2 570	Continued From page 10	2 570		

Continued From page 10

review, the facility failed to revise the care plan to include behaviors for 1 of 1 resident (R111) reviewed for behaviors; failed to revise the care plan to include oral status for 1 of 3 residents (R42) reviewed for dental services and failed to revise the care plan to include the risk for bruising for 1 of 4 residents (R68) reviewed for skin conditions.

Findings include:

R111's admission record, dated 11/18/15, indicated the resident had a diagnosis of unspecified dementia without behavioral disturbance.

R111's quarterly MDS, dated 2/22/16, indicated that the resident had physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) on 1 to 3 days in the past 7 days.

R111's care plan, dated 11/18/15, indicated that the resident had cognitive loss due to dementia, depression and disorientation. It recommended to watch for evidence of escalation of behaviors. If behavior escalates, make sure that the resident was safe and to come back to R111 at a later time. The care plan recommended using basic 3-5 word one-step commands; it advised when R111 was agitated (tossing and turning) have the resident up in her chair, when the resident was calm assist the resident back to her bed; when R111 was restless at night, staff were to assist the resident to her Broda chair at night and bring to the nurses station in addition to offering a warm blanket; it advised to monitor the interactions between R111 and other residents, staff and family members; it directed the staff to monitor R111's mood and behavior state.

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2 570	Continued From page 11 R111's pain assessment, dated 2/22/16, indicated that the resident would occasionally strike out. It recommended to continue to monitor the resident and offer non-pharmacological interventions and/or medications as ordered. The doctor should be notified as needed. R111's Kardex report (a guide for nursing assistants on caring for residents), dated 4/1/16, directed the nursing assistants in regards to any behaviors if the resident exhibited any restlessness, R111 might be cold. It instructed the nursing assistants' to put on R111's purple robe as this has brought comfort in the past. R111's behavior summary report, reviewed from 2/12/16 through 4/1/16, indicated that the resident exhibited 4 episodes of biting, 17 episodes of grabbing and 2 episodes of kicking/hitting. R111's progress notes, reviewed from 2/1/16 through 3/31/16 indicated the resident exhibited two episodes of striking out at staff. One episode occurred on 2/19/16 and a second episode occurred on 3/6/16. On 2/19/16, the staff began monitoring for pain in R111's feet due to her striking out at staff when foot cares were attempted. On 3/6/16, no interventions were done. When interviewed on 3/30/16 at 1:34 p.m., licensed practical nurse (LPN)-B stated that R111 would strike out at staff mostly at night, approximately once a week. LPN-B stated that at first the nursing assistants thought it might be due to the need to go to the bathroom but they determined it was not that. LPN-B stated that it appeared to be random acts with no rhyme or reason to the striking out.	2 570		

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When interviewed on 3/31/16 at 9:54 a.m., LPN-B stated that the nursing assistants would have to switch from a toothbrush to an oral swab if R111 had struck out at the staff. LPN-B stated that R111 had struck out at staff in the past.

When interviewed on 3/31/16 at 10:45 a.m., nursing assistant (NA)-K stated that R111 would grab at staff when performing oral cares. NA-K stated that R111 would strike out at staff "...if she doesn't like what you are doing." NA-K stated that R111 would strike out at staff when doing oral cares.

When interviewed on 4/1/16 at 10:16 a.m., NA-J stated that R111 did strike out at staff. NA-J stated that R111 would strike out at staff when doing cares approximately once or twice a week.

When interviewed on 4/1/16 at 12:20 p.m., RN-G stated that R111 had exhibited physical behavior from 1 to 3 days on the quarterly MDS. The physical behaviors that this would have included were: grabbing, pinching, scratching and spitting. RN-G stated this was documented only one time by the nursing assistants. RN-G stated there was no assessment for behaviors done on resident's. What would happen, if behaviors were observed, the nursing staff would monitor and document on any behaviors. This would have been in the nursing notes. Nursing assistants would also chart in the electronic system called point of care (POC). RN-G stated that if there was any documentation it would be in the nursing notes. RN-G did stated that the resident's behaviors should have been care planned.

When interviewed on 4/1/16 at 12:49 p.m., the director of nursing (DON) stated that the facility

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should have care planned the behaviors (specific to hitting). She stated that there should be interventions care planned which addressed these behaviors. The DON stated that the facility did not have an assessment specifically for a resident's behaviors. She explained that if a resident exhibited any behaviors, they would then tell the nurse. Once notified, the nurse would then address the behavior by initiating an "active problem" charting for two weeks. This was free texting where the nursing staff would be charting on the resident's actions over the course of two weeks. It would then be addressed from there.

Review of the facility policy titled, "Behavior Monitoring/ side effect monitoring (1/16)." The policy stated that the care plan would be initiated which utilized the date collected from the target behavior documentation on admission (if present), quarterly and with a significant change. It stated that the social worker, or designee, was responsible for developing and/or updating the resident mood and behavior sections of the care plan. The goal and interventions would be identified as discussed in the interdisciplinary team (IDT).

R42''s care plan dated 6/24/2014, indicated, "DENTAL CARE: I have a potential for impaired r/t [related to] dentures."

R42 was observed on 3/29/2016, at 9:43 a.m. in her room, appeared to have no teeth and was not wearing dentures.

R42 was observed on 03/31/2016, at 9:44 a.m. in her room, appeared to have no teeth and was not wearing dentures.

R42's annual Minimum Data Set Assessment

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(MDS) dated 4/29/15, indicated R42 had no natural teeth.

R42's Care Area Assessment (CAA) dated 4/29/15, indicated R42 had no natural teeth, and did not include a summary analysis to direct what should be included on the care plan for dental for R42.

R42's oral exam dated 1/13/16, indicated R42 had no natural teeth, did not wear dentures and the care plan was current.

R42's oral exam dated 10/14/15, indicated R42 had no natural teeth, did not wear dentures and the care plan was current.

R42's oral exam dated 4/16/15, indicated R42 had no natural teeth, did not wear dentures.

On 3/31/2016, at 10:25 a.m. nursing assistant (NA)-C stated she did not think R42 had any natural teeth and did not wear dentures.

On 3/31/2016, at 1:08 p.m. the director of nursing (DON) stated the oral assessment completed 1/13/16 indicated R42 had no natural teeth and did not have dentures. The DON stated the care plan indicated R42 was wearing dentures. The DON stated R42 did not have any dentures at the facility for her use and the care plan should have been revised to reflect R42 no longer wore her dentures.

The Care Plan policy with a review date of 1/16, indicated, "...The care plan must be reviewed and revised (updated) as necessary, but at least every three months..."

R68's care plan, print date 4/1/16, identified

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potential for alteration in skin integrity, incontinence and decreased mobility with interventions of: daily check for redness with a.m. cares under abdominal fold and buttocks crease and Aveeno lotion on back and arms BID (twice daily).

On 3/28/16, at 4:43 p.m., observation revealed R68 had two dark purple bruises on top of R68's right hand/wrist area. R68 stated the bruises were from old age.

R68's progress notes identified the following:
6/28/15, new bruise right forearm, 13 cm (centimeters) by 6.7 cm. R68 obtained the bruise when out on an outing.
12/15/15, bruise left knee, measured 2.7 cm by 3.2 cm dark purple in color, R68 does not remember what he bumped.

On 3/30/16, at 11:06 a.m., nursing assistant (NA)-H verified R68 had bruising on his right hand/wrist area. R68 stated at the time the bruising was from his watch. NA-H stated the facility system was the NA's usually report to the charge nurse when bruising is noted, then the charge nurse makes a report.

On 3/30/16, at 11:36 a.m., registered nurse (RN)-D verified R68 had two bruises located on his right hand/wrist area. RN-D stated we were not aware of the bruising. RN-D stated the nurse usually identified bruising during body audits on bath days or the NAs would report the bruising. Then a risk assessment would be completed, the size of the bruise would be documented and the bruising would be monitored until healed.

On 3/30/16, at 11:41 a.m., NA-I stated we assist R68 with all of his cares in the a.m. NA-I stated

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2 570	Continued From page 16 she had assisted R68 with getting dressed this a.m. NA-I stated, when queried if R68 had any skin concerns or bruising, R68 had very fragile skin, I put lotion on R68's arms and shoulders, I did not notice any skin concerns and R68 always has those bruises. On 4/1/16, at 10:40 a.m., the director of nursing stated she would expect bruising to be identified on the care plan as a problem area, as R68 has had bruising before. The facility Care Plan Policy, review date 1/16, indicated V. [five] concerns and problems B. Sources are, but not limited to: 8. Problems related to preventive care. 11. All problems requiring care. VII. [seven] Approach/Plan C. Individualized care for the unique needs of the resident. H. List preventive measures. IX. [nine] Review Date B. The care plan must be reviewed and revised (updated) as necessary. XII. [12] Resident Care Plan Documentation and Use of the Plan C. The resident care plan is used to plan and assign care for all disciplines. E. The resident care plan must be kept current at all times. F. Develop procedures to communicate all care plan information to the resident care staff. Suggested method of correction: The director of nursing (or designee) could review and make any necessary changes to care planning policies and provide education on revision of care plans. The facility then could audit care plans for accuracy and update as necessary. The facility then could develop and auditing system as part of their quality assurance program to maintain compliance. Time period of Correction: Twenty one (21) days.	2 570		

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2 830	Continued From page 17	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R125) who received dialysis services, had initial care plan to direct dialysis care, failed to ensure staff were trained in dialysis cares and failed to coordinate care with the dialysis center; in addition the facility failed to identify non-pressure related skin concerns for 1 of 4 residents (R86) reviewed for skin; failed to identify missing teeth on the comprehensive oral assessment for 1 of 3 residents (R86) reviewed for dental status and services; failed to identify and monitor bruising for 1 of 4 residents (R68) reviewed for skin; failed to ensure documentation of physician notification for a change of skin condition for 1 of 4 residents (R61) reviewed for skin condition; failed to follow a physician's order to obtain a lab value for 1 of 1 residents (R77) reviewed. Findings include:	2 830	Corrected	5/3/16

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2 830	Continued From page 18 LACK OF INITIAL CARE PLAN INTERVENTIONS TO ADDRESS DIALYSIS STATUS: Although R125 was new to dialysis treatments and had received three treatments since admission to the facility, there was no coordination of care completed with the dialysis center and facility to ensure R125 tolerated dialysis as follows: R125 was admitted on 3/23/16, with diagnosis of chronic kidney disease according to facility admission record. R125's admission progress note 3/23/16, identified R125 was alert and oriented, received a renal diet and fistula on left arm. During interview on 3/30/16, at 11:35 a.m., R125 stated received dialysis on Tuesdays, Thursdays, and Saturdays and had no fluid restriction. R125 revealed the dialysis access sight was a fistula located in the front of the left upper arm. During observations at this time the fistula site was uncovered, clean and dry. Document review of physician orders dated 3/24/16, revealed orders to monitor dialysis port on left antecubital (front surface of forearm), and make sure bruit is heard with stethoscope and thrill felt with palpation, every day and evening shift. Document review of facility pre-admission clinical assessment/interim care plan dated 3/23/16, identified diagnosis of renal insufficiency. The interim care plan lacked evidence of any dialysis care interventions such as: risk factors, potential complications and/or specific dialysis related care	2 830		

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needs, special nutritional and fluid volume needs, risks for adverse medication effects, care of the access site, infection control measures, skin care measures, monitoring of vital signs, weights and other monitoring requirements, such as before and after dialysis treatments, instructions for giving medications (to prevent dialysis treatments removing medication from the resident's system), coordinates care between the facility and dialysis center, and did not address the "Do Not Resuscitate" orders and advance directives.

During interview on 3/30/16, at 11:41 a.m., registered nurse (RN)-A stated not aware if R125 received fluid restriction. RN-A stated did not know what to do for R125 when returned from dialysis. RN-A stated if bleeding at fistula site, would apply pressure and call charge nurse.

During interview on 3/30/16, at 11:50 a.m., nursing assistant (NA)-A stated worked on R125's hall. NA-A stated not aware of location of dialysis access site, and if bleeding at site NA-A would call nurse. NA-A stated R125 was a new admission, had cared for R125 one day, and was scheduled for dialysis the following day. NA-A stated not aware of any special diet and did not know if fluids were restricted.

During interview on 3/30/16, at 11:55 a.m., RN-A looked at R125's treatment administration record (TAR) and stated the only dialysis treatment was for nurse to monitor dialysis port on left arm making sure the bruit was heard with a stethoscope and thrill felt with palpitation every day and evening shift. RN-A verified the TAR indicated licensed practical nurse-A (LPN-A) had already completed bruit and thrill check for that morning. During interview at that time, LPN-A stated had observed the dialysis port and had not

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monitored the bruit and thrill. When asked to observe the bruit and thrill check, RN-A and LPN-A stated they did not know how to monitor for bruit and thrill. LPN-A stated would get another nurse and left the floor.

During interview on 3/30/16, at 1:18 p.m.,NA-B verified was assigned to R125's hallway that day. NA-B stated not aware of location of dialysis access sight and did not know if received fluid restriction.

During interview on 3/30/16, at 1:20 p.m., RN-B stated the nurse who is responsible for R125's cares for the day needs to check the calendar and communicated dialysis appointments to nursing assistants who care for R125 on days of dialysis. RN-B stated expected nursing assistants to provide care according to nursing assistant kardex in facility computer system. At that time, RN-B verified the kardex identified R125 voided 1-2 times a day, no blood pressure in left arm, and daily weight. RN-B verified the nursing assistant kardex lacked identification of the dialysis port site, care of dialysis resident, diet, fluids, and emergency care. RN-B stated, if bleeding at dialysis port sight, staff knew to get the nurse. RN-B stated R125 had three dialysis visits since admission and verified no communication reports received from dialysis. RN-B stated R125 was not on fluid restriction. RN-B stated medications were administered as ordered and not aware of any medications that were to be held prior to dialysis treatments. RN-B verified R125's preadmission clinical assessment /interim care plan dated 3/23/16, indicated diagnosis of renal insufficiency, and no identification of dialysis care.

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During interview on 3/31/16, at 1:00 a.m., director of nursing stated she expected dialysis resident care plan to have dialysis needs identified.

Document review of facility Care of Dialysis Resident policy review date of 1/2016, revealed the following:

2. B. Nursing-frequent communication before and after dialysis will occur. A dialysis treatment record will be used by the dialysis provider during treatment and given to the skilled nursing facility staff after treatment as a summary and communication record. Although the policy addressed comprehensive care plan for dialysis care, the policy did not address initial dialysis care plan.

IDENTIFICATION AND MONITORING OF NON PRESSURE RELATED SKIN CONCERNS:

R86 was observed on 3/28/16, at 4:49 p.m. to have a bruises on the top of his right and left hands and right and left forearms with no documentation of these being found until the staff were informed of them by this surveyor on 3/31/16.

R86's signed physician orders included prednisone tablet give 5 mg (milligrams) by mouth in the morning for joint pain.

R86's body audit bath forms dated 3/28/16, 3/21/16, 3/14/16 and 3/7/16 did not identify any bruising to the tops of R86's hands or forearms.

R86's progress note dated 3/31/16 indicated, "New Bruise or Follow up: Bruising found on resident left forearm measuring 2 x 1.2 cm

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2 830	Continued From page 22 [centimeters] , 1 x 1.5 cm 3 x 2.4 cm, bruising also found on right elbow 19 x 2 cm, 4 x 8 cm and 3 x 1.5 cm. Information on Bruise: Bruising purple to light purple in color, resident denies any pain." R86's progress note dated 3/31/16 indicated, "New Bruise or Follow up: Bruises also found on left hand 1 x 1 cm [centimeters], 8 x 7 cm, 3 x 2 cm, right hand 14 x 8 cm." R86's plan of care dated 10/1014 instructed staff to, "monitor my skin with cares and with weekly bath." On 3/31/2016, at 10:25 a.m. nursing assistant (NA)-C stated residents' skin was monitored for bruises on their bath days when a complete skin assessment was completed by a nurse. NA-C also stated if we see any new concerns with bruising during daily cares, when we are washing them up in the morning, we alert the nurse. NA-C stated she was unaware of any bruising on R86 at this time. On 03/31/2016, at 12:51 p.m. the director of nursing stated there was no documentation in the medical record regarding the bruising on R86's arms or hands. The DON stated she expected staff to document and monitor bruises for healing. The DON stated on bath days a full skin assessment was completed by the nurse. The DON stated nursing assistants should be looking at skin during morning and evening cares and notify the nurse of any bruising. The DON stated residents' skin should be looked on a daily basis. A policy and procedure for monitoring non pressure related skin conditions was requested and none provided.	2 830		

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2 830	Continued From page 23 LACK OF COMPREHENSIVE DENTAL ASSESSMENT AND DEVELOPMENT OF INTERVENTIONS BASED ON THIS ASSESSMENT TO MEET THE NEEDS OF THE RESIDENT: R86 was observed on 3/28/2016, at 4:52 p.m. R86 was observed to be missing one tooth on top left side of the mouth and one tooth missing on the bottom right side of his mouth. R86's oral assessment dated 2/24/16, did not identify R86 had missing teeth or any dental concerns. R86's care plan revised 12/9/15, did not identify R86 had missing teeth or any dental concerns. On 3/31/2016, at 12:58 p.m. the director of nursing (DON) stated she reviewed the facility dental assessment and confirmed the assessment did not have an option to pick missing teeth for condition of natural teeth. The DON stated she expected staff to include missing teeth in the oral assessment and stated staff could indicate missing teeth under the comments section of the assessment. The DON stated she checked R86's oral assessments that had been completed by the facility and stated none of the assessments addressed R86's missing teeth. The DON stated there was nothing in the care plan for R86 that addressed missing teeth and stated R86's missing teeth should have been identified on the care plan. The Oral health policy with a review date of 1/16, instructed staff, "An oral health assessment will be done on admission, annually, quarterly and with a significant change in resident's condition by a registered nurse (RN)...Procedure:...condition	2 830		

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2 830	Continued From page 24 of natural and artificial teeth..." LACK OF IDENTIFICATION AND MONITORING OF BRUISING: R68 was observed on 3/28/16, at 4:43 p.m., to have two dark purple bruises on top of his right hand and wrist area. R68's quarterly Minimum Data Set dated 2/17/16, identified diagnosis of anemia. R68's progress notes identified R68 had prior bruising of the right forearm on 6/28/16, and the left knee on 12/15/15. R68's care plan was reviewed and did not include a problem area related to R68's risk for bruising, interventions to prevent bruising, nor interventions to implement if bruising was identified. On 3/30/16, at 11:06 a.m., nursing assistant (NA)-H verified R68 had bruising on his right hand and wrist area. NA-H stated the facility system was the NAs usually report to the charge nurse when bruising is noted, then the charge nurse makes a report. On 3/30/16, at 11:36 a.m., registered nurse (RN)-D verified R68 had two bruises located on his right hand and wrist area. RN-D stated we were not aware of the bruising. RN-D stated the nurse usually identified bruising during body audits on bath days or the NAs would report the bruising. Then a risk assessment would be completed, the size of the bruise would be documented and the bruising would be monitored until healed. On 3/30/16, at 11:41 a.m., NA-I stated she had	2 830		

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2 830	Continued From page 25 assisted R68 with getting dressed this a.m. NA-I stated, when queried if R68 had any skin concerns or bruising, R68 had very fragile skin, I put lotion on R68's arms and shoulders, I did not notice any skin concerns and R68 always has those bruises. On 4/1/16, at 10:40 a.m., the DON stated the facility system was anytime a NA sees a bruise the NA notifies the nurse. The nurse then measures the bruise and enters the information into risk management. Then around 24 hours after discovery we work on an intervention to put into place and try to find out how the bruise occurred. The DON stated she would expect the bruising to be reported and would expect bruising to be identified on the care plan as a problem area, as R68 has had bruising before. A policy for non-pressure skin conditions was requested, but not provided. R61 was observed on 3/30/16, at 1:27 p.m., with RN-D to have an area at the end of R61's right great toe that was dried, hard and dark brown in color. R61's quarterly Minimum Data Set dated 12/30/15, identified diagnosis of diabetes. R61's care plan, revised on 1/15/16, identified R61 was at risk for skin issues related to history of pressure ulcers and venous ulcers, anticoagulant medication use, venous insufficiency, vascular disease, incontinence, decreased mobility and edema. R61's progress notes identified the following: 3/18/16, incident: staff found what appears to be an old blood blister on resident's right great toe.	2 830		

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2 830	Continued From page 26 Area does not appear to be pressure as resident does not wear shoes and does not sleep with feet covered with blankets. His toe may have been pinched when pushing his chair up to the table at meal time. Resident is unaware of what happened. Area measures 1.7 cm (centimeters) by 1.8 cm. Interventions: Apply alkare daily. Physician notification: fax prepared. However, R61's record failed to include documentation of the fax prepared. 3/20/16, follow up incident, type of incident: resident sustained blood blister injury possibly from his feet hitting the dinner table. He does not wear shoes. He is unable to state what happened. Blister area now appears hard and scabbed over. Area around toe appears healthy. No drainage or bleeding. Will continue to monitor. Dx (diagnosis) that may have contributed include type two diabetes. Rx (medication) that may have contributed include metoprolol (beta blocker) and novolog insulin. 3/20/16, blister is dark red/purple in color. Has yellow dry skin on top. No drainage. 3/24/16, blister right great toe, dry with dried blood under skin. 3/25/16, document on blister of right great toe, 2 cm x 1.2 cm area with dried blood under skin and hard callous center. No discomfort. No open area. R61's physician progress note dated 3/24/16, per interview with the DON on 3/31/16, at 1:40 p.m., identified extremity poor foot perfusion. However, R61's record failed to include documentation of notification of R61's physician regarding the change in condition of R61's right great toe which included a diagnosis and treatment orders. On 3/30/16, at 1:27 p.m., RN-D stated she did not know if the area on R61's right great toe was a	2 830		

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2 830	Continued From page 27	2 830		

pressure area or not. RN-D stated she did not know if the area was measured weekly and she had completed the treatment yesterday and had not measured it. RN-D stated documentation for the treatment would be on the treatment administration record (TAR) and the TAR allowed for the nurse to make a progress note, which then would appear in R61's progress notes.

On 3/31/16, at 1:40 p.m., the DON verified R61's record lacked documentation of R61's physician being notified of the change in skin condition of the blister located on R61's right great toe.

The facility policy Change in Condition Notification, dated review date 1/16, indicated standards: attending provider or provider on call is to be notified of resident's change in condition/health status. Procedure: 1. Between reasonable business or typical wakeful hours, seven days a week, attending provider or provider on call is to be notified of all conditions or health status changes. 2. After hours, the attending provider or provider on call should be notified of any change in condition, health status or incident (list is not inclusive, examples only): Resulted in an injury having the potential for provider intervention .... 3. Document time of call, provider or other person spoken to, reason for call and results or orders received.

LACK OF FOLLOWING PHYSICIAN ORDERS IN THE TREATMENT FOR AN ACUTE HEALTH NEED:

R77's admission record, dated 1/22/16, indicated that the resident had diagnoses of: subsequent non-ST elevation (NSTEMI) myocardial infarction (heart attack), heart failure and hypertension.

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2 830	Continued From page 28 R77's hospital discharge summary, dated 1/17/16, indicated that the resident had been admitted to the hospital for a heart attack. The report summarized that R77 had been having EKG changes and an elevated troponin. R77's care plan, dated 1/23/16, indicated the resident was at risk for alteration in cardiovascular status. A Goal identified were that labs would remain within normal limits. It advised that R77 obtain lab tests as ordered. R77's progress notes, dated 3/4/16, indicated that the resident had new physician orders which stated, "Give Lasix [a medication used to decreased the amount of fluid in a body] 40 mg po [by mouth] now. Change Lasix to 80 mg po BID [twice a day] at 0800 and 1200 starting 3/5/17. Recheck BNP [a lab test used to determine if heart failure develops or worsens], BMP [a routine blood panel test] on 3/9/16." R77's blood chemistry report, dated 3/4/16, indicated that the resident had a BNP level of 2509. A normal reference range would be 10-263. A copy of R77's physician orders, dated 3/4/16 was handwritten and signed by the attending physician. It ordered a BNP to be completed on 3/9/16. R77's progress notes, reviewed from 3/9/16 through 3/31/16, did not indicate that the BNP had been completed as ordered. R77's blood chemistry report, dated 3/4/16 reviewed from 3/5/16 through 3/23/16, indicated that the BNP had not been done. When interviewed on 3/31/16 at 10:34 a.m.,	2 830		

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2 830	Continued From page 29	2 830		

registered nurse (RN)-I stated that the BNP had not been done on 3/9/16 as ordered. RN-I stated that the lab had not been done at all since 3/4/16. RN-I checked the computer system from the hospital and confirmed that the lab was not in the system.

When interviewed on 3/31/16 at 10:37 a.m., health unit coordinator (HUC)-D stated that the BNP had not been ordered; nor had it been done. HUC-D stated that once the physician ordered a lab, the HUC would then place it in the computer system; once this was done a nurse would check the order and confirm that it was in place. HUC-D stated that it had not been done in this case.

When interviewed on 4/1/16 at 12:58 p.m., the director of nursing (DON) stated that the staff should have followed the physician's orders and ordered the lab test to be performed.

Review of the facility policy titled, Provider Laboratory Orders (last reviewed 1/16) included: The lab values to be drawn on a resident per provider orders. It directed the HUC/nurse to transcribe an order with a due date in a lab book. A one-time order would be put in the lab book under "other." A HUC/nurse would fill out a lab slip when the lab was due. It then directed the notify the lab or the orders via inner mailing or phone.

Suggested method of correction:
The administrator and the director of nursing could review and revise policies and procedures to ensure residents received necessary care and services. The director of nursing could develop appropriate assessments to determine safety risks, provide education to licensed nursing staff

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2 830	Continued From page 30 on the assessments, analysis of the findings, implementation, and utilization. The facility could then develop an auditing system as part of their quality assurance program to maintain compliance. Time of Correction: Twenty one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices for catheter and perineal cares for 1 of 3 residents (R68) reviewed for urinary catheter; failed to ensure surveillance and analysis of infections. This had the potential to affect all residents, staff, and visitors. In addition, the facility failed to properly administer eye drops for 1 of 1 residents (R7) who received eye drop medication. Findings include: CATHETER AND PERINEAL CARES: On 3/31/16, at 7:27 a.m., nursing assistant (NA)-G washed hands, donned gloves and changed a catheter drainage bag to a catheter leg bag for R68. NA-G then with the same soiled gloves on applied R68's stockings, secured R68's	21375	Corrected	5/3/16

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21375	Continued From page 31 catheter tubing to R68's left thigh with a strap, opened the bathroom door, drained the urine out of R68's catheter drainage bag into the toilet, opened R68 room door to ask a staff person for a clean syringe/container (to be used to clean R68's catheter drainage bag) and removed gloves. Immediately following this observation NA-G, without washing hands placed R68's catheter drainage bag inside of a garbage can located in the bathroom. NA-G then placed the dirty gloves she had removed on top of the catheter bag, which was laid in the garbage can. NA-G then applied R68's shoes and walked R68 into the bathroom. NA-G then donned clean gloves, removed R68's incontinent product, which NA-G stated had bowel movement on the pad. NA-G placed the soiled incontinent product on top of R68's catheter bag laid in the garbage can. NA-G then with the soiled gloves grabbed a wash basin out of R68's room from a cupboard, placed the basin into the bathroom sink, opened R68's closet and obtained a clean incontinent product and assisted R68 with putting on the clean incontinent product. NA-G then with the same gloves on obtained R68's clothes, assisted R68 to remove his pajamas and handed R68 a washcloth to wash his face. NA-G then with the same soiled gloves on cleansed around R68's perineal catheter site and laid the washrag used to cleanse the perineal catheter site on top of R68's catheter drainage bag laid in the garbage can. NA-G then with the same soiled gloves on picked up a sterile bottle of normal saline and the clean syringe/container and placed them back down. NA-G then removed the soiled gloves, placed the dirty gloves and used syringe/container into the garbage can on top pf R68's catheter drainage bag. NA-G then opened R68's room door, walked out of R68's room into the hallway and obtained a clean a clean wash	21375		

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21375	Continued From page 32 cloth and towel from the linen cart. NA-G then walked back into R68's room and washed hands with hand sanitizer. NA-G failed to remove gloves and wash hands after removing a soiled incontinent product and after providing perineal cares. NA-G continued to provide R68 with cares and was observed to donn clean gloves, assisted R68 to stand and washed R68's buttocks with a wash cloth. NA-G then with the same soiled gloves on pulled up R68' pants and assisted R68 to walk back to bedside and sit down on R68's bed. NA-G then removed gloves, emptied out R68's wash basin, dried the wash basin out with a paper towel and disposed of the paper towel into the garbage can on top of R68's catheter drainage bag. NA-G failed to remove gloves and wash hands after cleansing R68's buttocks. NA-G then without washing hands, donned clean gloves and obtained R68's toothbrush, toothpaste and proceeded to brush R68's dentures. NA-G then with the same gloves on removed R68's soiled incontinent product and soiled wash cloth from the garbage, and placed the items in separate plastic bags. NA-G then with the same gloves on removed R68's catheter drainage bag from the garbage can and proceed to rinse the catheter drainage bag out two times using the clean syringe and container NA-G had filled with normal saline. NA-G then placed the catheter bag into a plastic bag and then put the bag containing the catheter bag into R68's night stand drawer. NA-G then removed gloves, opened the privacy curtain and washed hands. NA-G filed to remove gloves and wash hands after cleansing a urinary catheter bag and failed to ensure R68's had a clean catheter drainage bag after having placed the catheter drainage bag into a garbage can.	21375		

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21375	Continued From page 33 On 3/31/16, at 7:52 a.m., NA-G was interviewed about the observations made during the cares R68 had just received from NA-G. NA-G agreed that she had not removed soiled gloves or wash hands to prevent infection. NA-G, when queried regarding if R68 had any current infections replied, "Yeah, he has MRSA [Methicillin-resistant Staphylococcus aureus] in his urine." R68's medication administration record, dated 3/16, identified R68 was receiving Bactrim (antibiotic) DS (double strength) 800-160 mg (milligrams) one tablet two times a day for infection for 10 days. R68's progress note, dated 3/26/16, identified new order: Bactrim DS one two times daily for 10 days and the reason was for urinary tract infection, MRSA. On 3/31/16, at 1:22 p.m., registered nurse (RN)-C verified R68 was being treated with an antibiotic and had MRSA infection. RN-C stated she would expect gloves to be removed and hands washed after changing catheter bags, after cleansing around the perineal catheter site and after cleansing buttocks. RN-C stated she would want a new catheter bag to replace the catheter bag that had been laid in the garbage can. On 3/31/16, at 1:49 p.m., the director of nursing (DON) stated she would expect gloves to be removed right away and hands to be washed before touching other items after changing catheter bags, after cleaning the perineal catheter site, after cleansing buttocks and after changing a soiled incontinent product. The DON stated she would expect staff not to place the catheter drainage bag in the garbage can during use. The facility policy Care of Urinary Drainage and Leg Bags, dated 1/16, indicated procedure: 11.	21375		

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Connect tubing of drainage bag or leg bag to catheter. 12. Store leg/drainage bag in Ziploc bag in bedside stand when not in use after rinsing with sterile water. 13. Remove gloves and wash hands.

The facility policy Foley Catheter Care, dated 1/16, indicated procedure: 7. Cleanse perineal area with soap and water. 10. Dry perineal area. 11. Anchor catheter to thigh with catheter strap. Remove gloves and wash hands.

The facility policy Hand Washing, dated 3/16, indicated proper hand washing is the best way to prevent spread of disease. It protects both the employee and the resident. Procedure: 1. Hand Washing is done: b. After handling contaminated equipment, dressings, soiled linen, etc. g. after removal of gloves.

LACK OF A FUNCTIONING INFECTION PROGRAM WHICH INCLUDES SURVEILLANCE AND ANALYSIS:

The facility Monthly Infection Prevention and Control Reports were obtained from 4/2015 through 2/2016. The following information of infections were indicated on the monthly reports:
4/15, seven urinary tract infections (UTI's), four respiratory, two skin
5/15, four UTI's, five respiratory, two skin
6/15, five UTI's, three respiratory, three skin
7/15, four UTI's, three respiratory, one skin
8/15, four UTI's, six respiratory, two skin, one other
9/15, eight UTI's, three respiratory, three skin, one other
10/15, five UTI's, two respiratory, three skin
11/15, five UTI's, one respiratory, three skin

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21375	Continued From page 35 12/15, four UTI's, one respiratory 1/16, five UTI's, four respiratory, one skin 2/16, six UTI's, two respiratory, two skin The facility failed to document surveillance and analysis of the information and infection control precautions used to prevent the spread of the infection. On 3/31/16, at 1:04 p.m., RN-C stated she had no documentation of surveillance and analysis of the above information. RN-C stated we talk about hand hygiene and peri-cares during stand up, nurses and nursing assistant meetings and increased audits on nursing assistants providing peri-cares. The facility policy Infection Prevention and Control Program, undated, indicated I. The Infection Prevention Committee (IPC) is charged with overseeing the infection prevention program. This committee is responsible to the corporate and facility wide Quality Assurance Committee. The IPC carries the responsibility of surveillance, prevention, control and reporting of infection within the facility. The IPC provides program oversight, review and provides guidance of the infection control program, ensuring the facility's compliance to quality infection prevention standards. III. Infection Preventionist (IP), each facility shall designate an RN, to coordinate the process of the infection prevention program. The IP responsibilities include: 9. Managing surveillance of data (gathering, analysis and reporting processes). IV. Surveillance, The infection control surveillance is the process of data collection on nosocomial infection within the facility, as means for early detection of outbreaks. The surveillance data is additionally used to plan control activities and educational programs. A.	21375		

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The process 2. Recording, review, analysis and reporting of the case data is done monthly, quarterly and annually to detect trends. Educational and control efforts are assisted by this data.

LACK OF EYE MEDICAITON ADMINISTRATION TO PREVENT INFECTIONS:

R7's admission record, dated 2/26/04, indicated the resident had a diagnosis of a cataract.

R7's physician orders, dated 7/1/05, indicated the resident received artificial tear solution: 2 drops in both eyes two times a day related to dry eyes. The physician orders, dated 2/17/16, indicated that R7 received lubricant eye ointment: 1 ribbon was to be instilled in both eyes at bedtime related to cataracts.

During an observation of a medication administration on 3/28/16 at 6:37 p.m., registered nurse (RN)-F prepared the medications for R7. RN-F knocked on R7's door, entered and explained the procedure to R7. RN-F put on a pair of gloves and explained that R7 was to receive eye drops. RN-F took the bottle of artificial tears, and with one gloved hand, lowered the lower eyelid of the right eye. RN-F then touched the tip of the bottle of artificial tears to the sclera [the white outer layer] of the eyeball and administered one drop of artificial tears to the right eye. RN-F repeated this process with R7's right eye. RN-F did touch the sclera of R7's left eye as well. RN-F then prepared to administer lubricant eye ointment from a tube and explained the procedure to R7. With a gloved finger, RN-F lowered the lower eyelid of R7's right eye and administered a ribbon of ointment underneath the lower eyelid. RN-F again touched the tip of the

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tube where the medication was applied. RN-F repeated this process to the left eye. In the process, the tip of the tube of eye lubricant again touched underneath the lower left eyelid.

When interviewed on 3/28/16 at 6:42 p.m., RN-F stated that he might have touched underneath the lower lid of the left eye with the tip of the tube of eye lubricant.

When interviewed on 3/30/16 at 11:00 a.m., RN-J stated when administering eye medications, the nurse should never touch the eyeball with the tip of the container. RN-J stated that if a resident were to have an infection (such as pinkeye) in one eye, the infection would spread from one eye to the other.

When interviewed on 4/1/16, at 12:43 p.m., the director of nursing (DON) stated that the nurse who administered the eye drops as well as the eye lubricant should not have touched the eye with the tip of the medication containers.

Review of the document titled, "Administering Eye Medications (1/16)," it explained the proper procedure for administering eye medications. It stated, "Avoid touching the dropper against the eye or anything else."

SUGGESTED METHOD OF CORRECTION: The infection control coordinator (or designee) could review infection control program policies and procedures then provide any necessary education. The facility could develop and implement a system for surveillance and analysis of infections. The facility could then develop and implement an auditing system for the program as part of their quality assurance program to maintain compliance.

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21375	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 employees (NA-L) and 1 of 5 residents (R77) received a tuberculin skin testing (TST) according to the Centers for Disease Control and Prevention (CDC) guidelines; failed to ensure 1 of 5 employees (HUC- F) reviewed had TB education; failed to ensure the facility Tuberculosis (TB) infection	21426	Corrected	5/3/16

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control program included all areas as required; failed to develop a written infection control plan that included procedures for early recognition and isolation for handling persons with active TB disease as required. This had the potential to affect all residents, staff and visitors.

Findings include:

LACK OF TWO STEP TST ACCORDING TO THE CDC GUIDELINES FOR STAFF:

Nursing assistant (NA)-L's employee personnel record was reviewed and identified NA-L was hired on 12/21/15, and had a first step TST on 7/7/15, with reading of 0 mm (millimeters) on 7/9/15. The first step TST recorded failed to be dated within 90 days of hire as required.

On 3/31/16, at 12:35 p.m., registered nurse (RN)-C verified the above.

LACK OR TB COMPLIANCE PER CDC GUIDANCE FOR RESIDENTS:

R77 was admitted on 1/22/16. R77's TB screen dated 1/22/16, indicated R77 had an adverse reaction to a TB TST. R77's chest x-ray dated 1/16/16, indicated the reason for the x-ray was for a fall. The chest x-ray failed to address TB as required.

On 3/31/16, at 12:35 p.m., RN-C said for both R77 and NA-L the requirement for CDC TB guide was not completed.

LACK OF TB MANDATED TRAINING PER CDC:

Health unit coordinator (HUC)-F was identified on 3/31/16, at 7:59 a.m., by the director of nursing

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(DON) to not have had TB education. The DON stated HUC-F would attend in May 2016 and the reason HUC-F had not attended was due to HUC-F attends school. The DON verified HUC-F's hire date was 1/23/16, and HUC-F was working on the floor and had contact with residents.

TB INFECTION CONTROL PROGRAM LACKED THE FOLLOWING:

Review of the facility policy TB Control Plan, dated 2015, indicated each facility shall: form infection control TB team. This can be a team of one or more depending on size of the facility.

However the policy failed to identify how many persons were on the infection control team for the facility and who the persons were.

In addition, the policy failed to include written infection control procedures and failed to address TB health care worker education.

Also the facility policy TB Control Plan, dated 2015, indicated if a resident develops symptoms of TB a TST is to be administered and resident is transferred to appropriate facility, and notify MDH [Minnesota Department of Health] of possible case.

The TB infection control plan failed to include written TB infection control procedures for early recognition and isolation for residents with active TB.

In addition, the policy failed to include information about working with the local or state public health department to conduct a TB contact investigation

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21426	Continued From page 41 if health care-associated transmission of M. tuberculosis is suspected. On 3/31/16, at 12:35 p.m., RN-C verified the current policy lacked information in regards to above. The facility policy TB Control Plan, dated 2015, indicated the facility shall develop a TB Control Plan in compliance with current CDC TB Infection Control guidelines and consistent with the Minnesota Occupational Health and Safety (OSHA) TB requirements. SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate all employees regarding TB education and the facility infection control plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled according to physician's orders for 3 of 25 medications reviewed during medication administration. This affected 3 of 8 residents (R7, R72, R107).	21620	Corrected	5/3/16

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Findings include:

R7 was observed during a medication administration on 3/28/16 at 6:37 p.m., registered nurse (RN)-F administered one ribbon of lubricant eye ointment in each eye of R7. The label on the medication instructed staff to administer twice daily to the right eye only.

R7's admission record, dated 2/26/20014, indicated that the resident had a diagnosis of a cataract.

R7's physician orders, dated 2/17/16, instructed that the resident was to receive lubricant eye ointment 1 ribbon in each eye at bedtime.

When interviewed on 3/28/16 at 6:42 p.m., RN-F stated that the label on the lubricant eye ointment was incorrect. RN-F stated that the correct procedure when an order had changed by the physician was to put a "change of directions" sticker on the medication which indicated that the order had changed. That would notify the nursing staff to look at the actual physician's order.

R72 was observed during a medication administration on 3/30/16 at 1:41 p.m., RN-J administered 0.5 mg (milligrams) of Ativan (an antianxiety medication) to R72. The label on the medication instructed to administer Ativan 0.5 mg four times a day and as needed 1/2 hour prior to treatment.

R72's admission record, dated 12/11/13, indicated that the resident had a diagnosis of generalized anxiety disorder.

R72's physician orders, dated 12/17/15, indicated that the resident was to receive Ativan 0.5 mg

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four times a day.

R72's medication administration record, reviewed from 3/1/16 through 3/31/16, indicated that the resident had received Ativan as prescribed by the physician.

When interviewed on 3/30/16 at 3:32 p.m., licensed practical nurse (LPN)-D stated that the label on R72's Ativan medication was incorrect. LPN-D stated that there should have had a "change of direction" sticker placed on the medication packet to indicate to the nursing staff that the orders had changed. LPN-D stated that when an order was changed, the pharmacy was also notified so when a new prescription was sent it would have the correct order written on it.

R107 was observed during a medication administration on 3/31/16 at 7:15 a.m., RN-H administered 1000 mg of Tylenol to R107. The label on the medication instructed that R107 was to receive 1000 mg twice a day and every 6 hours as needed for pain greater than 5 on a 0 to 10 scale with 10 being the most excruciating.

R107's admission record, dated 10/15/15, indicated the resident had a diagnosis of a fracture of the first thoracic vertebra.

R107's physician orders, dated 10/20/15, indicated that the resident had an order for Tylenol.

R107's medication administration record, reviewed from 3/1/16 through 3/31/16, indicated that the resident received Tylenol 1000 mg by mouth two times a day for pain.

When interviewed on 3/31/16 at 8:35 a.m., RN-H

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stated that the label on the Tylenol for R107 was incorrect. RN-H stated that the medication packet needed a "change of direction" sticker affixed to it in order to indicate to the nursing staff the order was different from what was written on the medication package. RN-H then did place a "change of direction" sticker on the medication.

When interviewed on 4/1/16 at 12:45 p.m., the director of nursing (DON) stated that the staff should have placed "change of direction" stickers on the medications to indicate that there was a differing order from the instructions on the package. The DON stated that the pharmacy should be notified in order to get the instructions changed on future medication orders.

Review of the policy titled, "Administering Medication (1/16)," it instructed that the nurse was responsible for checking to see the drug and dosage schedule on the resident's medication administration record (MAR) matched the label on the medication container. If the medication container was marked with a label which indicated a recent change in the directions for the use of the medication or there was any reason to question the dosage or the dosage interval, the nurse was to check the provider's orders for clarifications.

SUGGESTED METHOD OF CORRECTION: The pharmacist or Director of Nursing could in-service staff responsible for medication administration to monitor all meds needing accurate dispensing labels.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21665	Continued From page 45	21665		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure wheelchair legs were covered with a cleanable surface for 1 of 1 resident (R31) whose wheelchair legs were covered with a foam like substance. Findings include: R31's wheelchair legs were covered with a foam like substance. R31 had diagnosis that included osteoporosis, hemiplegia and hemiparesis, according to facility admission record. Observations on 3/29/16, at 9:50 a.m., revealed staff pushed R31 in a wheelchair to R31's room. Observations at that time revealed both wheelchair legs were covered with foam like substance held in place with straps. During interview on 3/31/16, at 10:30 a.m., environmental services director verified the foam covering wheelchair legs. He stated the surface was porous and not a cleanable surface. He stated physical therapy had requested the wheelchair legs be covered for resident safety. During interview on 3/31/16, at 2:03 p.m.,	21665	Corrected	5/3/16

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21665	Continued From page 46 registered nurse (RN)-C verified wheelchair legs were covered with a foam substance and not a cleanable surface. RN-C stated the facility lacked a policy related to non-cleanable surfaces. SUGGESTED METHOD OF CORRECTION: The administrator and environmental services director could review and revise policies and procedures to ensure use of padding with cleanable surfaces. The director of nursing could in-service all staff to ensure cleanable surfaces were used. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to promote confidentiality of medical and personal information for both oral and written forms for 2 of 2 residents (R73 and R51) reviewed for confidentiality and privacy.	21855	Corrected	5/3/16

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21855	Continued From page 47 Findings Include: R73's family member (FM)-A was interviewed on 3/29/16 at 12:42 p.m., when asked, "Does the staff speak privately (without being overheard) about your relative's/friend's medical or behavioral condition?" FM-A responded, "No, they speak to me about concerns wherever I may be. So if I happen to be in the hall they talk to me in the hall and it is not done privately." On 03/31/2016 at 1:57 p.m., the director of nursing (DON) stated she expected staff to communicate with families in a private area. The DON stated speaking to a family member in the hallway about a resident's medical or behavioral concerns would not be private. The DON confirmed the facility policy instructed staff to not discuss patient information in a public area. The Privacy/Dignity Policy with a review date of 1/16 included, "...Patient information will not be discussed in a public area." R51's medical information was in full view of anyone in the country view hall on 03/31/16, at 7:11 a.m. A computer screen mounted on the hallway wall was open, and any person that walked down the hallway pass the screen was able to view the information on the screen. The screen identified the following health information for R51: R51's first and last name, room number, weekly tub bath, bowel movements, laniseptic cream [skin protectant] to sacrum every shift, Teds [compression stockings] on in a.m., calmoseptine [topical ointment] to upper thighs and peri-area with cares, turn and reposition every two hours, every shift bed mobility, check areas of moisture abdominal folds, under breasts,	21855		

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buttocks crease daily during care, daily with a.m. cares to check redness under breasts, abdominal folds, and buttocks crease, grippy socks on when in bed at all times and Vaseline to corners of mouth every a.m.

On 3/31/16, at 7:11 a.m., a construction worker walked by the screen. At 7:12 a.m., registered nurse (RN)-E, a construction worker and nursing assistant (NA)-G walked by the screen. At 7:15 a.m., a construction worker walked by the screen. At 7:17 a.m., NA-G walked by the screen. At 7:18 a.m., nursing assistant (NA)-E walked by the screen. At 7:20 a.m., construction worker (CW)-C walked by the screen and verified there were three construction workers currently working on construction in the country view hallway. At 7:22 a.m., one resident was left by staff sitting in a wheelchair in front of the screen and another resident walked by the screen independently with a walker. At no time did the staff secure the resident's information on the computer from unauthorized visual access.

On 3/31/16, at 7:25 a.m., NA-G verified the screen was open and R51's health information was on the screen. NA-G stated sometimes the screen does not close and NA-G then closed the screen.

On 3/31/16, at 1:40 p.m., the DON stated she would expect the screen to be closed out when the staff leaves the screen.

The DON provided information of the HIPPA [Health Insurance Portability and Accountability Act] passed in 1996, which indicated protected health information, anything that identifies the individual: computer monitors are not exposed to public view.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ______ B. WING ______	04/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21855	Continued From page 49 Suggested method of correction: The director of nursing (or designee) could review their HIPPA policies and procedures, review and make any necessary changes to privacy and confidentiality training program, and provide education to staff members. The facility could then develop and implement an auditing system that is part of their quality assurance program to maintain compliance. Time period of correction: Twenty one (21) days.	21855		