DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: VG2D

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	AGENCY		Facility	ID: 00770
MEDICARE/MEDICAID PROVIDE	DER	3. NAME AND AD					4. TYPE OF	ACTION:	7 (L8)
NO.(L1) 245218		(L3) MAYO CLIN			- LAKE CITY		1. Initial	2. I	_ Recertification
2. STATE VENDOR OR MEDICALL (L2) 715522100	O NO.	(L4) 500 WEST ((L5) LAKE CITY		EET	(L6)	55041	3. Terminati 5. Validation		CHOW Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>02</u> (L7)		7. On-Site V	isit 9. (Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Surv	ey After Compla	nint
6. DATE OF SURVEY 6/2	1/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF				
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR	ENDING DAT	ΓE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		09/3	0	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		x A. In Complia	nce With		And/Or Appro	ved Waivers Of	The Following Red	quirements:	
To (b):		Program Re	•		2. Tech	nical Personnel	6. Scor	e of Services I	imit
		•	e Based On:		3. 24 H			ical Director	
12.Total Facility Beds	90 (L18)	1. A	cceptable POC		_	y RN (Rural SN		nt Room Size	
13.Total Certified Beds	90 (L17)	B. Not in Comp	liance with Progr	am	5. Life	Safety Code	9. Beds	/Room	
		Requirements	and/or Applied \	Waivers:	* Code:	A	(L12)		
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY N	MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15	5)	
90									
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE)·					
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17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	EVEY AGENCY	APPROVAL	Da	ate:
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PA	RT II - TO BE	COMPLETED H	BY HCFA RI	EGIONAI	OFFICE OF	SINGLE S'	TATE AGENO		
19. DETERMINATION OF ELIGIBI	LITY	20. COM	IPLIANCE WITI	H CIVIL	21. 1. S	tatement of Finan	icial Solvency (HC	FA-2572)	
1. Facility is Eligible to	Participata		ITS ACT:		2. C	wnership/Contro	l Interest Disclosur		1513)
2. Facility is not Eligible	-				э. Б	oth of the Above	·		
2. Themey is not Englos	(L21)								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	I. LTC AGREEN	MENT	26. TERMINA	ΓΙΟΝ ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY	00	IN	VOLUNTARY	
03/20/1978					01-Merger, Clos			Fail to Meet He	ealth/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction	on W/ Reimburse	ment 06-	Fail to Meet Ag	reement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involu	intary Termination	n OT	<u>HER</u>	
	A. Suspension	of Admissions:			04-Other Reason	for Withdrawal		Provider Status	s Change
(T. 27)			(L44)				00-	Active	
(L27)	B. Rescind Su	spension Date:							
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
				,					
31. RO RECEIPT OF CMS-1539	1. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE								

(L33)

DETERMINATION APPROVAL

(L32)



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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



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

Kumala Fiske Downing

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

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

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

		POST-0	ERTI	FICATION	N REVISIT F	REPORT			
	ER / SUPPLIER / CLIA / ICATION NUMBER	MULTIPLE CON	ISTRUCTIO	N				DATE OF REV	/ISIT
245218	Y1	A. Building B. Wing					Y2	6/21/2016	Y3
_	F FACILITY				STREET ADDRESS, O		CODE		
MAYO C	CLINIC HEALTH SYSTE	EM - LAKE CITY	(500 WEST GRANT ST LAKE CITY, MN 5504				
					LAKE CITT, MIN 5504	I			
program correcte provision	ort is completed by a q n, to show those deficie ed and the date such co n number and the ident rey report form).	ncies previously rrective action	reported ovas accom	on the CMS-256 plished. Each d	 Statement of Deficition Efficiency should be full 	encies and Plar ully identified usi	n of Correcting either th	tion, that have ne regulation o	r LSC
ITE	EM .	DATE	ITEM		DATE	ITEM		DAT	E
Y4	ļ	Y5	Y4		Y5	Y4		Y5	
ID Prefix	F0280	Correction	ID Prefix	F0309	Correction	ID Prefix		Corre	ection
Reg. #	483.20(d)(3), 483.10(k) (2)	Completed	Reg. #	483.25	Completed	Reg. #		Comp	oleted
LSC		06/15/2016	LSC		06/15/2016	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Corre	ection
Reg. #		Completed	Reg. #		Completed	Reg. #		Comp	oleted
LSC		- -	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Corre	ection
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Reg. #		Completed	Reg. #		Completed	Reg. #		Comp	oleted
LSC		_	LSC			LSC			
			1			1			

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

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?

ID Prefix

Reg. #

LSC

Correction

Completed

Correction

Completed

ID Prefix

Reg. #

LSC

ID Prefix

Reg. #

LSC

Correction

Completed



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,

Kumalu Fiske Downing

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

					STAT	E FOI	RM: RE	VISIT I	REPORT				
PROVIDE IDENTIFIC				MULTIPLE CON A. Building	ISTRUCTIO	N						DATE (OF REVISIT
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NAME OF		-			_				T ADDRESS, C		ZIP CODE		
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corrective	e action tion pref	was a	ccomplis	tate surveyor to shed. Each def usly shown on t	iciency sho	ould be	fully iden	tified us	ing either the	regulation or	r LSC provision	n numbe	er and the
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Y4				Y5	Y4				Y5	Y4			Y5
ID Prefix				Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #	MN Rule Subp. 4	4658.0	0405	Completed	Reg. #	MN Ru Subp.	le 4658.05 1	20	Completed	Reg.#			Completed
LSC				06/15/2016	LSC				06/15/2016	LSC			
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LSC				-	LSC					LSC			
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REVIEWE CMS RO	ED BY		REVIEV (INITIAL		DATE		TITLE					DATE	

Page 1 of 1 EVENT ID: VG2D13

YES NO

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

4/1/2016

FOLLOWUP TO SURVEY COMPLETED ON

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: VG2D

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY	AGENCY		Facility ID: 00770
MEDICARE/MEDICAID PROVI NO.(L1) 245218 STATE VENDOR OR MEDICAI (L2) 715522100		3. NAME AND AL (L3) MAYO CLII (L4) 500 WEST ((L5) LAKE CITY	NIC HEALTH GRANT STRE	SYSTEM		55041	4. TYPE OF AC 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visi 8. Full Survey	it 9. Other After Complaint
6. DATE OF SURVEY 05/8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L14) (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR E	NDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	90 (L18) 90 (L17)	Compliance1. A B. Not in Comp		am	2. Tech 3. 24 F 4. 7-Da 5. Life	nnical Personnel	7. Medica	of Services Limit al Director Room Size
14. LTC CERTIFIED BED BREAKD	OWN	1		1	15. FACILITY		()	
18 SNF 18/19 SNF		ICF	IID		1861 (e) (1) on		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
Marietta Lee, HFI	E NE II		5/8/2016	(L19)	Kamala Fiske-l	Downing, Health	n Program Represe	entative 7/19/2016 _(L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OF	R SINGLE S'	TATE AGENCY	
DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible.	Participate		MPLIANCE WITH	H CIVIL	2. (ncial Solvency (HCFA ol Interest Disclosure : :	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 03/20/1978	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos			DLUNTARY il to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction	on W/ Reimburse	ement 06-Fa	il to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	untary Termination for Withdrawal	OTHI	ovider Status Change
(L27)	B. Rescind Su	uspension Date:					00 7 K	ATTC
20 TERMINATION DATE	20	DITED MEDIA DV	(L45)		20 DEMARKS			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	DATE				
	(L32)			(L33)	DETERMIN	ATION APPR	ROVAL	



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

Kamala Fiske Downing

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

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245218	B. WING		05	R 5/ 17/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CO 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	TS	{F 00	00}		
{F 280} SS=D	completed on May tags that were corr CMS2567B. Also t found corrected at are located on the Because you are esignature is not recepage of the CMS-2 submission of the verification of computer of the verification. 483.20(d)(3), 483. PARTICIPATE PLATE The resident has the incompetent or oth incapacitated under participate in plant changes in care are an A comprehensive as interdisciplinary teaphysician, a register of the resident, and disciplines as detered and, to the extent put the resident, the resident, the resident, the resident at a computer of the resident, the resident of the versident of the versident, the resident of the versident of the versident of the versident, the resident of the versident o	enrolled in ePOC, your quired at the bottom of the first e2567 form. Your electronic POC will be used as pliance. acceptable electronic POC, an our facility will be conducted to antial compliance with the en attained in accordance with a lo(k)(2) RIGHT TO anning CARE-REVISE CP one right, unless adjudged erwise found to be ear the laws of the State, to sing care and treatment or	{F 28	(0)		6/15/16
L ABORATOR'	 Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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

Electronically Signed

6/8/2016

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COM	E SURVEY PLETED
		245218	B. WING				17/2016
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(X4) ID PREFIX TAG	and revised by a team of qualified persons after each assessment.		ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 280}	and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced		{F 28	30}			
	by: Based on observatoreview, the facility for comprehensive carfor 1 of 3 residents status and services. Findings include: R31 had been observations are the facility opened and and upper teeth. R31 had a dental and and upper teeth. R31 had a dental and and upper teeth. R31 had a dental and upper teeth. R31 had	ion, interview, and document ailed to revise the e plan in regards to oral care (R31) reviewed for dental. erved on 5/16/16, at 3:28 p.m. n eyes closed with mouth could visualize natural lower appointment on 4/13/16. The n report included "Patient was uning today. Patient has heavy ner entire mouth. Her tissues and puffy. I am sending a which will help clean along the eeds to have teeth brushed is too tired at night they can be			R31 consult was sent to Physician signature. Careplan/kardex was refor dental services which included toothbrush. Oral assessment was completed. All resident care plans were update include dental services. New flow sheet created to be used resident returns from consult appointment. Nursing staff will be educated on upcare plans. Education will be done on the new consultation appointment flow sheet Audits of the newly created consult to be completed two times a week Health Unit Coordinator for 3 month random audits thereafter. Oral care audits will be done 4 times week for 3 months. The QAPI teams be reviewing the audits and making necessary process changes as appropriate. DON is responsible to ensure completed to the surface of the	vised curved ed to when odating et. sheet by ns, and es a n will	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COM	E SURVEY IPLETED
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{F 280}	licensed practical neare plan did not in reported the dental return included red sent a curved tooth day. LPN-F indicate guide instructed stahad not been updatorders. During an interview registered nurse (Recommendations comprehensive car During an observat nursing assistant (Neuroyor the curved looked around R31 find the curved toot "What do you use to often?" NA-B report toothbrush, someting depending on what stated most of the toral care. During an interview director of nursing (Should have been recommendations. Facility policy Care included, "The care revised (updated) at three months. Probinust be reviewed and necessary; three limit. Three more reasonable for certifical sent and the curve and reasonable for certifical sent and the sent and necessary; three limit. Three more reasonable for certifical sent and the sent and necessary; three limit. Three more reasonable for certifical sent and the sent and necessary; three limit. Three more reasonable for certifical sent and the sent and	on 5/16/16, at 3:38 p.m. urse (LPN)-F reported the clude a dental focus. LPN-F visit on 4/13/16 orders on and puffy tissues and had brush to be used twice per ed the nursing assistant care aff to brush and floss daily but ed to include the dentist's		80}			

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COM	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	1 03/	17/2010
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{F 309} SS=D	Each resident must provide the necess or maintain the high mental, and psychological expensions.	CARE/SERVICES FOR EING t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment	{F 309	}		6/15/16
	by: Based on observareview, the facility frelated skin injury for reviewed for non prelimings included; R111 had been observating assistant (Nowhirlpool tub bath. The size of a small light purple be bruises were not now both feet on the servedness on the "known the left foot had surrounding redness going to report the sand NA-O said that they should have be bath R111 had this During an interview licensed practical in NA-O had not report on R111. During an interview registered nurse (Figure 2)	tion, interview, and document ailed to identify a non-pressure or 1 of 3 residents (R111) ressure skin injuries. Served on 5/17/16, at 9:13 a.m. NA)-O finished giving R111 a There was a light purple bruise ime, and below that one was a ruise. NA-O remarked the ew because of the color. Also cond toe showed areas of uckle" of the toe. The third toe a small scabbed area with as. NA-O was asked if she was are reddened areas on the toes a she did not have too because een reported during the first week. Ton 5/17/16, at 10:04 a.m. urse (LPN)-C reported that red any skin integrity issues		R111 scratch was entered into ris management. Treatment started entered onto Treatment Record. Physician and family were notified plan updated. Reviewed the bath body audit poli Nursing Assistants to be educated notifying nurse on change in skin condition. Nursing staff/HUCs will be re-edu on the bath body audit policy. DON /Staff Educator will observe weekly on bath day that body audit accurate and complete for one mo DON / Staff Educator will review 6 audits each week for 3 months. QAPI team will review the audits a make necessary process changes appropriate. DON is responsible to ensure com	and Care cy. I on cated R 111 t is onth. body The and s as	

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245218	B. WING			R
NAME OF I	PROVIDER OR SUPPLIER	243210	D. Willa	STREET ADDRESS, CITY, STATE		17/2016
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY		500 WEST GRANT STREET LAKE CITY, MN 55041	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
{F 309}	impaired skin integrity scabbed area and recentimeters (cm) by redness measurem RN-B stated NA's a impaired skin integrity with cares and skin concerns they nurse then assessed document, and notically orders. Facility policy Skin 4/16 included, "Any integrity with a non-receive prompt thorappropriate healing notify the nursing sith complete approprial also gave direction the standing orders.	ng measuring the areas of rity. RN-B indicated the redness on the third toe was iffied. The scab measured 0.2 y 0.2 cm with surrounding lents of 1.0 cm by 0.8 cm. are to report any areas of	{F 3	09}		

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	/ISIT
	B. Wing		Y2	5/17/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MAYO CLINIC HEALTH SYSTE	EM - 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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. #	F0164 483.10(e), 483.	Completed	Reg. #	F0279 483.20(d), 483.20(k)(1)	Correction	ID Prefix Reg. #	F0281 483.20(k)(3)(i)		Correction Completed
LSC		05/03/2016	LSC		05/03/2016	LSC			05/03/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	183.25(h)	Completed	Reg. #	483.60(a),(b)		Completed
LSC		05/03/2016	LSC		05/03/2016	LSC			05/03/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.60(b), (d), (Completed	Reg. #	183.65	Completed	Reg. #			Completed
LSC		05/03/2016	LSC		05/03/2016	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		-	LSC			
REVIEWS		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR			DATE	
REVIEWS CMS RO		GPN/kfd REVIEWED BY (INITIALS)	6/1/2016 DATE	TITLE 15425			5 DATE	/17/2016	
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 N					s 🗆 NO		

		POST-C	ERITFIC	ATION REVISIT	REPORT		
	ER / SUPPLIER / CL			0.04		DATE	OF REVISIT
245218	ICATION NUMBER	A. Building 01 - B. Wing	MAIN BUILDIN	G 01		_{Y2} 5/4/20)16 _{Y3}
NAME O	F FACILITY			STREET ADDRESS,	CITY, STATE, ZIP CC	DDE	
MAYO C	CLINIC HEALTH S	YSTEM - LAKE CITY	•	500 WEST GRANT S			
				LAKE CITY, MN 5504	41		
program correcte provision	i, to show those de d and the date suc	ficiencies previously ch corrective action v	reported on the	ledicare, Medicaid and/or Clinic e CMS-2567, Statement of Defi ed. Each deficiency should be shown on the CMS-2567 (prefix	ciencies and Plan of fully identified using	f Correction, that either the regul	t have been lation or LSC
ITE	М	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
	NFPA 101		NEPA	101	-		=
Reg. #		Completed	Reg. # 	Completed	Reg. #		Completed
LSC	K0154	05/04/2016	LSC K015	5 05/04/2016	LSC		-
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		_
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
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Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		_
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Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		-
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		-
REVIEW	ED BY RI	EVIEWED BY	DATE	SIGNATURE OF SURVEYOR		DATE	
STATE A	GENCY [] (II	NITIALS) TL.kfd	6/1/2016		7008	5/4	1/2016

FOLLOWUP TO SURVEY COMPLETED ON

REVIEWED BY

(INITIALS)

DATE

REVIEWED BY

CMS RO

3/29/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

TITLE

YES NO

DATE



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

Kamala Fiske Downing

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

PRINTED: 07/26/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
					R		
		00770		B. WING		05/1	7/2016
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S GRANT ST	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY		Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{2 000}	Initial Comments			{2 000}			
	*****	NTION*****					
	NH LICENSING	CORRECTION ORDI	ΞR				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Departments of the Minnesota Departments of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected. You may request a that may result from orders provided that the Department with notice of assessments.	nether a violation has compliance with all rule provided at the talle number indicated the several items, failuathe items will be consumed the items will be consumed from the items of multi-part rule of a fine even if the items on any assess the non-compliance with the items of a fine even if the initial inspectation.	ssued on, it is cited violation dance rule of been ag below. re to idered upon ule will the item tion was sments in these made to of a e.				
	16 & 17, 2016. Duri	ng this onsite visit it w following two correct orrected. 3.0405 Subp. 4	<i>r</i> as				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/08/16 **Electronically Signed**

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				B. WING		3
		00770			05/1	7/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S T GRANT ST	STATE, ZIP CODE		
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{2 000}	Continued From pa	ge 1	{2 000}			
	effect and will be re	cted orders will remain in viewed at the next onsite visit. ders will be reviewed for sessments.				
{2 570}	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	{2 570}			6/15/16
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.				
	by: Uncorrected based Based on observati review, the facility for comprehensive car for 1 of 3 residents status and services Findings include: R31 had been obse R31 was in bed with slightly opened and and upper teeth. R31 had a dental a Dentist consultation seen for dental clea	e plan in regards to oral care (R31) reviewed for dental		corrected		

Minnesota Department of Health

STATE FORM 6899 VG2D12 If continuation sheet 2 of 6

PRINTED: 07/26/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		7. BOILDING.		R		
	00770	B. WING			7/2016	
NAME OF PROVIDER OR SUPPLI	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MAYO CLINIC HEALTH SYS	TEM LAKE CITY 500 WES	T GRANT ST	REET			
MATO CLINIC HEALTH ST.	LAKE CIT	Y, MN 5504	1			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 570} Continued From	page 2	{2 570}				
[gums]are very recurved toothbrus gum line. Patient twice a day. If she brushed after su R31's care plan needed]." also is staff to meet hygupdated interver directions an retrained with a management of the curved tooth guide. During an intervilicensed practical care plan did not reported the den return included retu	ed and puffy. I am sending a h which will help clean along the needs to have teeth brushed e is too tired at night they can be	{2 370}				

Minnesota Department of Health

STATE FORM 6899 VG2D12 If continuation sheet 3 of 6

Minnesota Department of Health

AND BLAN OF CORRECTION \ \ \ IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED		
00770			B. WING 05			R / 17/2016	
	PROVIDER OR SUPPLIER	FM - LAKE CITY 500 WEST	ORESS, CITY, ST GRANT ST Y, MN 5504				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
{2 570}	stated most of the toral care. During an interview director of nursing (should have been recommendations. Facility policy Care included, "The care revised (updated) at three months. Prob must be reviewed a and necessary; three limit. Three moreasonable for certaplans may need to are obtained." The original licensing 2016, will remain in orders will be review assessments.	ime R31 was cooperative with on 5/17/16, at 2:55 p.m. (DON) indicated the care plan evised to include the dentist's Plan last reviewed 1/16 plan must be reviewed and is necessary, but at least every lems, goals, and approaches and revised when appropriate be months is the maximum onths may be too long and not ain short-term goals. Care be revised when new orders and order issued on April 1, effect. Also uncorrected wed for possible penalty	{2 570}			6/15/16	
[2 556]	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from to	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	[2 000]			0/13/10	

6899

Minnesota Department of Health STATE FORM

VG2D12 If continuation sheet 4 of 6

PRINTED: 07/26/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
712 . 271	0. 0020		A. BUILDING:			
		00770	B. WING		F 05/1	२ 7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		500 WES1	GRANT ST	REET		
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY LAKE CIT	Y, MN 5504	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ige 4	{2 830}			
,	This MN Requirem	ent is not met as evidenced	,			
	by: Uncorrected based Based on observati review, the facility f related skin injury for reviewed for non pr Findings included; R111 had been obsenursing assistant (N whirlpool tub bath, the size of a small I small light purple by bruises were not not both feet on the second redness on the "knoth feet on the second provided in the size of a small I small light purple by bruises were not note to the second provided in the second provided p	on the following findings: ion, interview, and document ailed to identify a non-pressure or 1 of 3 residents (R111) ressure skin injuries. served on 5/17/16, at 9:13 a.m. NA)-O finished giving R111 a There was a light purple bruise ime, and below that one was a ruise. NA-O remarked the rew because of the color. Also cond toe showed areas of ruckle" of the toe. The third toe a small scabbed area with as. NA-O was asked if she was be reddened areas on the toes a she did not have too because been reported during the first week. If on 5/17/16, at 10:04 a.m. are to measuring the areas of rity. RN-B indicated the redness on the third toe was aified. The scab measured 0.2 by 0.2 cm with surrounding tents of 1.0 cm by 0.8 cm. are to report any areas of rity. a on 5/17/16 at 3:00 p.m.		Corrected		
		(DON) reported NA's monitor are to report to the nurse any				

Minnesota Department of Health

STATE FORM 6899 VG2D12 If continuation sheet 5 of 6

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00770	B. WING		F 05/1	₹ 7/2016		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MAYO C	CLINIC HEALTH SYSTE	-M-IAKECIIV	T GRANT ST TY, MN 5504					
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{2 830}	skin concerns they nurse then assessed document, and noting any orders. Facility policy Skin In 4/16 included, "Any integrity with a non-receive prompt thor appropriate healing notify the nursing sucomplete appropriate also gave direction the standing orders care plan and imples The original licensing 2016, will remain in	find. DON explained that the es and treat the skin, ify the physician and update. Integrity-Non pressure dated resident with a break in skin pressure area of the skin will rough treatment to ensure pure to ensure and document and attended to notify the physician, follow for skin care, and update the ement monitoring schedule. In gorder issued on April 1, a effect. Also uncorrected wed for possible penalty.	{2 830}					

6899

Minnesota Department of Health STATE FORM

			STAT	E FORM: RE	VISIT REPORT					
	CATION NUMBER	MULTIPLE CON A. Building B. Wing					Y2	DATE (OF REV	ISIT Y3
_	F FACILITY LINIC HEALTH SYSTE	-		STREET ADDRES 500 WEST GRANT LAKE CITY, MN 55	STREET		1			
correctiv	ort is completed by a Si e action was accomplisation prefix code previourm).	hed. Each defi	iciency sho	ould be fully iden	tified using either	the regulation	or LSC provisio	n numb	er and t	he
ITE	M	DATE	ITEM		DATE	ITEM			DATE	
Y4		Y5	Y4		Y5	Y4			Y5	
ID Prefix	20560	Correction	ID Prefix	20565	Correctio	n ID Prefix	21375		Corre	ction
Reg. #	MN Rule 4658.0405 Subp. 2	Completed	Reg. #	MN Rule 4658.04 Subp. 3	O5 Complete	d Reg. #	MN Rule 4658.08 Subp. 1	800	Comp	leted
LSC		05/03/2016	LSC		05/03/2016	LSC			05/03/2	2016
ID Prefix	21426	Correction	ID Prefix	21620	Correctio	n ID Prefix	21665		Corre	ction
Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN Rule 4658.13	45 Complete	d Reg. #	MN Rule 4658.14	400	Comp	leted
LSC		05/03/2016	LSC		05/03/2016	LSC			05/03/2	2016
ID Prefix	21855	Correction	ID Prefix		Correctio	n ID Prefix			Corre	ction
Reg. #	MN St. Statute 144.651 Subd. 15	Completed	Reg. #		Complete	d Reg.#			Comp	leted
LSC		05/03/2016	LSC			LSC			-	
ID Prefix		Correction	ID Prefix		Correctio	n ID Prefix			Corre	ction
Reg. #		Completed	Reg. #		Complete	d Reg. #			Comp	leted
LSC		-	LSC			LSC			-	
ID Prefix		Correction	ID Prefix		Correctio	n ID Prefix			Corre	ction
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LSC		-	LSC			LSC			=	

REVIEWED BY STATE AGENCY		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE	
		` GPN/kf	06/01/2016	15425		5/17/2016	
REVIEWED BY CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
		C OUTON FOR ANY INCORPROTER REFIGIENCIES WAS A SUMMARY OF					

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

EVENT ID:	VG2D12	

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

		10 22 00::111	3515557		E SCH / ET HOEHOT		Tuellity 12. 00770
1. MEDICARE/MEDICAID PROVID NO.(L1) 245218	DER	3. NAME AND AI (L3) MAYO CLI			- LAKE CITY	4. TYPE OF ACTI	ON: <u>2</u> (L8) 2. Recertification
2. STATE VENDOR OR MEDICAII (L2) 715522100	O NO.	(L4) 500 WEST ((L5) LAKE CITY		EET	(L6) 55041	3. Termination 5. Validation	4. CHOW6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other er Complaint
6. DATE OF SURVEY 04/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other)1/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	90 (L18) 90 (L17)	Compliance1. A X B. Not in Con	equirements e Based On:	gram	And/Or Approved Waivers Of 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: * Code: * B	1 6. Scope of S 7. Medical D	Services Limit prirector pm Size
14. LTC CERTIFIED BED BREAKDO	OWN		- 11		15. FACILITY MEETS		
18 SNF 18/19 SNF 90	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Marietta Lee, HFE	NEII		04/25/2016	(L19)	Kamala Fiske-Downing, Heal	th Program Representa	tive 05/23/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligible	Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:			21. 1. Statement of Fina2. Ownership/Contr3. Both of the Abov	rol Interest Disclosure Stm	
22. ORIGINAL DATE	23. LTC AGREE	MENT 2/	4. LTC AGREEN	MENT	26. TERMINATION ACTION	·	(L30)
OF PARTICIPATION 03/20/1978	BEGINNING		ENDING DA		VOLUNTARY 01-Merger, Closure	<u>0</u> <u>INVOLU</u>	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER	der Status Change
(L27)	B. Rescind St	uspension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	PROVAL	



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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,

Kumalu Fiske Downing

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

PRINTED: 04/25/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	` '	E SURVEY IPLETED
		245218	B. WING	_		04/	01/2016
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTE	EM - LAKE CITY		Ę	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	FO	000			
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 164 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(e), 483.75(l)	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with (4) PERSONAL ENTIALITY OF RECORDS	F 1	164			5/3/16
		e right to personal privacy and sor her personal and clinical					
	medical treatment, communications, po meetings of family a	cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private lent.					
	section, the residen	in paragraph (e)(3) of this at may approve or refuse the and clinical records to any he facility.					
	and clinical records resident is transferr	to refuse release of personal does not apply when the red to another health care direlease is required by law.					
LABORATOR'	 Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245218	B. WING _		04/0	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CO 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 164	The facility must ke contained in the resthe form or storage release is required healthcare institution contract; or the residual contract.	ep confidential all information sident's records, regardless of methods, except when by transfer to another on; law; third party payment	F 10	64		
	Based on interview facility failed to pror and personal inform forms for 2 of 2 res reviewed for confide. Findings Include: R73's family memb 3/29/16 at 12:42 p.r staff speak privately about your relative's behavioral condition they speak to me a be. So if I happen to in the hall and it is r. On 03/31/2016 at 1 nursing (DON) state communicate with f DON stated speaking hallway about a resconcerns would not confirmed the facility discuss patient info	and document review, the mote confidentiality of medical nation for both oral and written idents (R73 and R51) entiality and privacy. er (FM)-A was interviewed on m., when asked, "Does the y (without being overheard) softend's medical or not more." FM-A responded, "No, bout concerns wherever I may be in the hall they talk to me not done privately." :57 p.m., the director of ed she expected staff to families in a private area. The ident's medical or behavioral to be private. The DON ty policy instructed staff to not rmation in a public area.		Time out screens have bee the two minutes and nursing been educated to lock applic leaving application. All staff will be re-educated to update residents/families room or in a private place, narea. Audits will be done 2 times a Social Services, Activities, Nurse and Health Unit Coord 3 months and random there Results will be reviewed by the social services.	staff have cation prior to cation prior to on HIPPA and in resident so tif any public a week by light Charge dinators times after.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04/	01/2016	
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 164	anyone in the county: 11 a.m. A computable hallway wall was on walked down the hall hable to view the inforce identified the for R51: R51's first weekly tub bath, but cream [skin protect Teds [compression calmoseptine [topic and peri-area with every two hours, evareas of moisture abuttocks crease data cares to check redifolds, and buttocks in bed at all times a mouth every a.m. On 3/31/16, at 7:11 walked by the screen (RN)-E, a coassistant (NA)-G wa.m., a construction At 7:17 a.m., NA-G a.m., nursing assis screen. At 7:20 a.m walked by the screet three construction in the a.m., one resident wheelchair in front resident walked by a walker. At no time	imation was in full view of try view hall on 03/31/16, at ter screen mounted on the pen, and any person that allway pass the screen was primation on the screen. The efollowing health information and last name, room number, owel movements, laniseptic ant] to sacrum every shift, stockings] on in a.m., cal ointment] to upper thighs cares, turn and reposition very shift bed mobility, check abdominal folds, under breasts, ily during care, daily with a.m. ness under breasts, abdominal crease, grippy socks on when and Vaseline to corners of a.m., a construction worker en. At 7:12 a.m., registered instruction worker and nursing alked by the screen. At 7:15 in worker walked by the screen. At 7:18 that (NA)-E walked by the screen. At 7:18 that (NA)-E walked by the interest currently working on country view hallway. At 7:22 was left by staff sitting in a of the screen independently with the did the staff secure the on on the computer from	F 1	64			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 164 F 279 SS=D	screen was open a was on the screen. screen does not closcreen. On 3/31/16, at 1:40 would expect the so the staff leaves the The DON provided [Health Insurance FAct] passed in 1996 health information, individual: compute public view. 483.20(d), 483.20(b) COMPREHENSIVE A facility must use to develop, review a comprehensive pla. The facility must deplan for each reside objectives and times	a.m., NA-G verified the nd R51's health information NA-G stated sometimes the ose and NA-G then closed the p.m., the DON stated she creen to be closed out when screen. Information of the HIPPA Portability and Accountability S, which indicated protected anything that identifies the remonitors are not exposed to (A)(1) DEVELOP E CARE PLANS The results of the assessment and revise the resident's of care. Evelop a comprehensive care ent that includes measurable stables to meet a resident's	F 1		DEPIGIENCY)		5/3/16
		nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	describe the services that are ttain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04/01/2016	
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTI	EM - LAKE CITY	5	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 279	by: Based on observareview, the facility for 1 of 1 resident services. Findings include: R111's admission rewas admitted to the R111's admission of the R111's care plan, of the resident was unindependently and related to her demonstrated to her demonstrated to assistants on cares	NT is not met as evidenced tion, interview and document ailed to develop a plan of care (R111) reviewed for dental ecord indicated the resident a facility on 11/18/15. Minimum Data Set (MDS), icated that the resident had no needed extensive assistance er with personal hygiene. DS did not indicate whether the oblems with her teeth. It needed extensive assistance ers with personal hygiene. ated 11/18/15, indicated that hable to groom herself needed extensive assistance entia. art (used to instruct nursing a for each resident), dated ontain any information in	F 279	,	nd tal	
	resident had artifici of the time. The res	dated 2/22/16, stated that the al teeth which were worn most sident was observed to have tar in two spots on her artificial				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245218	B. WING _		04	/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP COL 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	stated that the residentition problem. During an observed her lower palate. During an observat a.m., nursing assist resident with dress hygiene at this time. When interviewed on nursing assistant (Note that the dentures on the lower palate) the dentures on the lower proom. NA-H stated the cup with water to NA-H stated that af the resident's reman NA-H stated that should be the denture of the cup with water to NA-H stated that af the resident's reman NA-H stated that should be the denture of the cup with water to NA-H stated that should be the denture of the cup with water to NA-H stated that should be the denture of the cup with water to NA-H stated that should be the cup with water to NA-H stated that should b	ssessment, dated 2/26/16, dent had a chewing and ion on 3/29/16 at 9:29 a.m., d to have two missing teeth on ion of cares on 3/31/16 at 7:37 tant (NA)-H assisted the ing. NA-H did not perform oral		9		
	cavity was assesse were currently in a a few teeth remaini LPN-B stated that F in her mouth. When interviewed of licensed practical in nursing assistants processed.	d. The resident's dentures cup of water. The resident had ng on her bottom palate. R111 did not keep her dentures on 3/31/16 at 9:54 a.m., urse (LPN)-B stated that the perform oral cares for R111 by with a tooth brush. LPN-B				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245218	B. WING			04/0	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP 500 WEST GRANT STREET LAKE CITY, MN 55041	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPI	BE	(X5) COMPLETION DATE
F 279	cares twice a day. on the resident if sl toothbrush; LPN-B started striking out to use oral swabs t stated that the residente past. LPN-B started striking out to use oral swabs t stated that the residente past. LPN-B started strike past. LPN-B started strike past. LPN-B started that residente with pink oral swab and to perform oral care first explain to R11 when performing on having the residente when the sure that R1 NA-J would swab FNA-J stated that she worked was afraid to use a resident would bite NA-J stated that what admitted to the fact a toothbrush when described that R11 toothbrush and not when interviewed director of nursing	inge 6 is should be performing oral LPN-B stated that it depended the allowed the staff to use a stated that if the resident then they staff would attempt to complete oral cares. LPN-B dent had struck out at staff in ated that specific oral cares for probably been care planned. In 3/31/16 at 10:45 a.m., INA)-K stated that R111 had ald have her dentures cleaned evening. NA-K described prior to cleaning R111's mouth s. NA-K stated that she would leaten a meal in the morning es. NA-K	F 2	279			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04/	/01/2016	
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 279	information would he the nursing assistant R111 as well.	ne DON stated that the nave been put in the Kardex so nts would know how to care for	F2	279			
F 280 SS=D	indicated V. [five] c. Sources are, but no related to preventive requiring care. VII. Individualized care resident. H. List presented and revised (update Resident Care Planthe Plan C. The resident Care planthe Plan C. The resident must be and assign care for care plan must be and assign care for the resident, and disciplines as deter and, to the extent p	0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F 2	280		5/3/16	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245218	B. WING		04/0	1/2016	
	PROVIDER OR SUPPLIER	EM - LAKE CITY	5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041	Y, STATE, ZIP CODE REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	and revised by a te each assessment. This REQUIREMED by:	e; and periodically reviewed am of qualified persons after NT is not met as evidenced	F 280				
	review, the facility finclude behaviors freviewed for behaviors freviewed for behaviors for the viewed for behavior for 1 of 4 residents conditions. Findings include: R111's admission rindicated the reside unspecified demendisturbance. R111's quarterly Mithat the resident has symptoms directed pushing, scratching sexually) on 1 to 3 R111's care plan, difference behavior escalates was safe and to co	tion, interview and document ailed to revise the care plan to or 1 of 1 resident (R111) iors; failed to revise the care status for 1 of 3 residents dental services and failed to not include the risk for bruising (R68) reviewed for skin ecord, dated 11/18/15, ent had a diagnosis of tia without behavioral DS, dated 2/22/16, indicated ad physical behavioral toward others (hitting, kicking, g, grabbing, abusing others days in the past 7 days. ated 11/18/15, indicated that ignitive loss due to dementia, orientation. It recommended to of escalation of behaviors. If make sure that the resident me back to R111 at a later recommended using basic		R111 careplan was revised to inclube haviors, R42 for dental services a R68 for skin conditions. R42 had oral assessment done with careplan updated. R42 care profile been updated to current status. Skin integrity task in Point of Care in Click Care has been initiated to autropoulate for all residents, to capture skin issues, document by Nursing Assistants, with prompt to report to Resident care plans will be reviewer evised as indicated per MDS schedupon noted changes and prn. Nursing staff to be re-educated to necessary changes and revision of plans. Audits to be completed two times eweek by DON or designee for 3 mc Results will be reviewed by QAPI terminated.	and h h h h h h h o e h o e noted Nurse. d and dule, care ach onths.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245218	B. WING _		04	1/01/2016
-	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	3-5 word one-step R111 was agitated resident up in her calm assist the res R111 was restless the resident to her to the nurses statio warm blanket; it ad interactions betwee staff and family me monitor R111's mone R111's pain assess that the resident we recommended to cand offer non-pharmand/or medications should be notified a R111's Kardex reports assistants on carindirected the nursing behaviors if the resident we restlessness, R111 nursing assistants' as this has brought R111's behavior su 2/12/16 through 4/1 exhibited 4 episode grabbing and 2 episone R111's progress not through 3/31/16 incompared on 3/6/16 monitoring for pain	commands; it advised when (tossing and turning) have the chair, when the resident was ident back to her bed; when at night, staff were to assist Broda chair at night and bring on in addition to offering a dvised to monitor the en R111 and other residents, embers; it directed the staff to od and behavior state. Sement, dated 2/22/16, indicated build occasionally strike out. It ontinue to monitor the resident macological interventions as ordered. The doctor	F 28	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04	/01/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 500 WEST GRANT STREET LAKE CITY, MN 55041		01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	attempted. On 3/6/done. When interviewed licensed practical resolution would strike out at approximately once first the nursing as to the need to go to determined it was appeared to be rar reason to the striki. When interviewed stated that the nurse switch from a tooth had struck out at the R111 had struck out. When interviewed nursing assistant (grab at staff when stated that R111 we doesn't like what you R111 would strike cares. When interviewed stated that R111 distated that R111 we doing cares approximately on the stated that R111 we doing cares approximately on the stated that R111 had stated that R111 we doing cares approximately once interviewed stated that R111 had stated that R111	on 3/30/16 at 1:34 p.m., nurse (LPN)-B stated that R111 staff mostly at night, e a week. LPN-B stated that at sistants thought it might be due to the bathroom but they not that. LPN-B stated that it adom acts with no rhyme or	F 2	80		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STAT 500 WEST GRANT STREET LAKE CITY, MN 55041	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
F 280	What would happed the nursing staff wo any behaviors. This nursing notes. Nursing notes and the should have dead the should have been on the nursing should have care put to hitting). She stating these behaviors. The did not have an assessident's behavior resident exhibited at tell the nurse. Once address the behavior resident exhibited at tell the nurse. Once address the behavior resident where the non the resident's according where the non the resident had the which utilized the dependent of the facility of	behaviors done on resident's. n, if behaviors were observed, build monitor and document on s would have been in the sing assistants would also nic system called point of care d that if there was any ould be in the nursing notes. at the resident's behaviors	F2	280			

		A. BUILDIN	IG	001	MPLETED
	245218	B. WING _		04	/01/2016
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE	E CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	<u> </u>	, , , , , , , , , , , , , , , , , , , ,
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE IT REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280 Continued From page 12 R42"s care plan dated 6/24// "DENTAL CARE: I have a por/t [related to] dentures." R42 was observed on 3/29/2 her room, appeared to have wearing dentures. R42 was observed on 03/31, her room, appeared to have wearing dentures. R42's annual Minimum Data (MDS) dated 4/29/15, indicar natural teeth. R42's Care Area Assessmer 4/29/15, indicated R42 had redid not include a summary a should be included on the care plan was current. R42's oral exam dated 1/13/had no natural teeth, did not the care plan was current. R42's oral exam dated 10/14/had no natural teeth, did not the care plan was current. R42's oral exam dated 4/16/had no natural teeth, did not the care plan was current. R42's oral exam dated 4/16/had no natural teeth, did not the care plan was current. R42's oral exam dated 4/16/had no natural teeth, did not the care plan was current. R42's oral exam dated 4/16/had no natural teeth, did not the care plan was current.	2016, at 9:43 a.m. in no teeth and was not 2016, at 9:44 a.m. in no teeth and was not 2016, at 9:44 a.m. in no teeth and was not 2016, at 9:44 a.m. in no teeth and was not 2016. Set Assessment ted R42 had no 2016 no natural teeth, and nalysis to direct what are plan for dental for 2016, indicated R42 wear dentures and 2016, indicated R42 wear dentures and 2016, indicated R42 wear dentures. 1016, indicated R42 wear dentures and 2016, indicated R42 wear dentures. 1017, indicated R42 wear dentures. 1018, indicated R42 wear dentures.	F 28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245218	B. WING _		04	/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CO 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 280	did not have dentur plan indicated R42 DON stated R42 di facility for her use a been revised to refl dentures. The Care Plan policindicated, "The carevised (updated) at three months" R68's care plan, pr potential for alterati incontinence and dinterventions of: da cares under abdom and Aveeno lotion of daily). On 3/28/16, at 4:43 R68 had two dark pright hand/wrist are from old age. R68's progress not 6/28/15, new bruise (centimeters) by 6. when out on an out 12/15/15, bruise lef 3.2 cm dark purple remember what he On 3/30/16, at 11:0 (NA)-H verified R68 hand/wrist area. R6 bruising was from h	A42 had no natural teeth and res. The DON stated the care was wearing dentures. The d not have any dentures at the and the care plan should have lect R42 no longer wore her by with a review date of 1/16, are plan must be reviewed and as necessary, but at least every lint date 4/1/16, identified on in skin integrity, ecreased mobility with ily check for redness with a.m. hinal fold and buttocks crease on back and arms BID (twice p.m., observation revealed ourple bruises on top of R68's a. R68 stated the bruises were right forearm, 13 cm of cm. R68 obtained the bruise ring. It knee, measured 2.7 cm by in color, R68 does not	F 28			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245218	B. WING			04/0	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	charge nurse make On 3/30/16, at 11:30 (RN)-D verified R68 his right hand/wrist not aware of the brusually identified broath days or the NAThen a risk assessing size of the bruise with bruising would be more of the bruise with all of his constant of th	bruising is noted, then the s a report. 6 a.m., registered nurse had two bruises located on area. RN-D stated we were using. RN-D stated the nurse using during body audits on as would report the bruising. The ment would be completed, the ould be documented and the nonitored until healed. 1 a.m., NA-I stated we assist ares in the a.m. NA-I stated 68 with getting dressed this hen queried if R68 had any using, R68 had very fragile R68's arms and shoulders, I kin concerns and R68 always a.m., the director of nursing spect bruising to be identified a problem area, as R68 has	F 2	280			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245218	B. WING _		04/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 280 F 281	Develop procedure information to the re	kept current at all times. F. s to communicate all care plan	F 28		5/3/16
SS=D	must meet professi This REQUIREMEN	TANDARDS led or arranged by the facility onal standards of quality. NT is not met as evidenced			
	review, the facility find plan with intervention the time of admission reviewed for dialysion ensure proper techninhaler medication.	ion, interview and document ailed to develop an initial care ons based on health needs at on for 1 of 1 resident (R125) is services; and failed to nique of administration of an for 1 of 1 residents (R10) ation administration.		Resident R125 discharged from fa on 3/23/16. Policy and procedure for Hemodialy residents was revised. Education on Dialysis was added to nursing cheat sheet books and to N and Nursing Assistant preceptor sh Charge nurse admit/readmit check revised to include update careplan/ if on dialysis. Nursing staff to be educated on dia	ysis o our lurse eet. list Kardex
	ADDRESS HEALTH R125 was admitted chronic kidney dise admission record. During interview on stated received dial and Saturdays. R1 access sight was a the left upper arm. uncovered, clean a fluid restriction. Obs	OIALYSIS CARE PLAN TO H NEEDS: on 3/23/16, with diagnosis of ase according to facility 3/30/16, at 11:35 a.m., R125 ysis on Tuesdays, Thursdays, 25 revealed the dialysis fistula located in the front of The fistula site was and dry. R125 stated no diet or servations at that time glass or pitcher in the room.		care of Bruit/Thrill. Audit has been developed for dialys for future admissions and will be completed upon dialysis admission DON or designee. Resident R10 will be asked to swist spit with water post taking her inhal Nursing staff to be re-educated to ginhalation medication according to directions. Pharmacy Nurse Consultant will do random med pass audits every weemonths. Results of audits to DON follow-up required. Audits will be reviewed by QAPI tea	by h and er. give ek for 3 for any

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa		F 28	1		
		progress note 3/23/16, s alert and oriented, received a la on left arm.				
	assessment/interir identify needed he Comprehensive capost admission) caidentified diagnosis interim care plan la care interventions complications and needs, special nutrisks for adverse naccess site, infectimeasures, monitoring reand after dialysis to giving medications removing medicatic coordinates care by	of facility pre-admission clinical in (interim or initial care plan to alth needs prior to the are plan completed 21 days are plan dated 3/23/16, so of renal insufficiency. The acked evidence of any dialysis such as: risk factors, potential for specific dialysis related care ritional and fluid volume needs, nedication effects, care of the on control measures, skin care ring of vital signs, weights and equirements, such as before reatments, instructions for (to prevent dialysis treatments on from the resident's system), between the facility and dialysis address, "Do Not Resuscitate" the directives.				
	3/24/16, revealed on left antecubital make sure bruit is	of physician orders dated orders to monitor dialysis port (front surface of forearm), and heard with stethoscope and tion, every day and evening				
	registered nurse (Freceived fluid rest know what to do fo dialysis. RN-A state	n 3/30/16, at 11:41 a.m., RN)-A stated not aware if R125 riction. RN-A stated did not or R125 when returned from ed if bleeding at fistula site, ure and call charge nurse.				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245218	B. WING		04/	01/2016
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTE	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 281	nursing assistant (N wing. NA-A stated dialysis access site call nurse. NA-A stated admission, had car scheduled for dialystated not aware of know if fluids were During interview on looked at R125's tro (TAR) and stated the for nurse to monito making sure the bro stethoscope and the day and evening shindicated licensed palready completed morning. However, LPN-A stated had not monitored asked to observe the and LPN-A stated to monitor for bruit and another nurse and During interview on of nursing stated she care plan to be contimely. Document review on Resident policy revalthough the policy	3/30/16, at 11:50 a.m., NA)-A stated worked on R125's not aware of location of, and if bleeding at site would ated R125 was a new ed for R125 one day, and was sis the following day. NA-A any special diet and did not restricted. 3/30/16, at 11:55 a.m., RN-A eatment administration record the only dialysis treatment was a dialysis port on left armulit was heard with a rill felt with palpitation every lift. RN-A verified the TAR bractical nurse (LPN)-A had bruit and thrill check for that during interview at that time, observed the dialysis port and the bruit and thrill. When he bruit and thrill check, RN-A hey did not know how to do d thrill. LPN-A stated would get left the floor. 3/31/16, at 1:00 a.m., director the expected dialysis resident in prehensive and completed addressed comprehensive is care, the policy did not	F 28			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245218	B. WING			04/0	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	R10's admission reindicated the resided R10's order summa indicated that R10 vacrosol 220 mcg/actimes a day related R10's medication a reviewed from 3/1/1 that the resident hat HFA Aerosol medications. R10 h Flovent inhaler to ta R10's door and explay was time for her medications. R10 h Flovent inhaler to the R10's door and explay was time for her medications and tablet. R10 never rithe Flovent inhaler medications. When not advised to rinse Flovent inhaler, LP1 resident took sips of tablets, that sufficed	NHALATION MEDICATION DIRECTIONS: cord, dated 10/5/2012, and had a diagnosis of asthma. ary report, dated 8/3/2011, was prescribed Flovent HFA at: 2 puffs by inhalation two to asthma. dministration record (MAR), and the foliation of a medication deep receiving the Flovent ation as ordered. It is a medication with the foliation as ordered. It is a medication with the foliation of a medication with the foliation with the foliations. R10 raised up in four had been shaken, LPN-C to the resident. R10 took two form the foliations. R10 took two form the foliations. R10 then took disped water. R10 then took disped water after taking a fine of the mouth out after using the form the foliations of the foliations	F 2	281			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245218	B. WING _		04/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	1 0 11 0 11 0 11
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLÉTION
F 281	director of nursing (should have rinsed directly after using fine the facility of Metered Dose In any information on out after usage ever Administration (FD) usage of the Flover user to rinse the more should have a should be s	on 4/1/16 at 12:43 p.m., the (DON) stated that the resident her mouth out with water	F 28	31	
F 282 SS=D	483.20(k)(3)(ii) SER PERSONS/PER CA The services provided be accordance with eacare. This REQUIREMENT by: Based on observation review, the facility for	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in ich resident's written plan of NT is not met as evidenced tion, interview and document ailed to follow the care plan rs for 1 of 3 residents (R85) on and the facility failed to	F 28	Thickened liquids policy was revis Nursing/Dietary staff to be re-educ provide services and treatments a directed in the comprehensive car	cated to s
	follow the care plan cares for 1 of 3 resi bruises, reviewed for conditions. Findings include:	on and the facility falled to to observe skin with daily idents (R86) observed to have or non pressure related skin		plan/Kardex, and dietary card at ta Audit to be completed by Dietary Supervisors each meal two times week, for 3 months. Results will be reviewed by QAPI team. R86, skin integrity task has been initialized for documentation of ski integrity every shift in the point of or	able. each e

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	R85's care plan, pinas a risk for fluid/poor intake, nectardiscontinue from simechanical soft teconsistency, okay R85 is at risk for insignificant weight Indecreased appetite of high kcal, high pinas R85's physician or an order for high pinechanical soft tewater protocol, thir on 3/30/16, at 12:3 sitting in a wheelch the noon meal. R8 centimeters) of regulation of the sitting in a wheelch the noon meal. R8 centimeters of regulation of the sitting in a wheelch the noon meal. R8 centimeters of regulation of the sitting in a wheelch the noon meal. R8 centimeters of regulation of the sitting in a wheelch the noon meal. R8 independently. No observed to be sitting and was encouraging R85's dietary sheel R85's food, indication calorie, mechanical on 3/30/16, at 12:3 (RN)-D verified R8 on 3/30/16, at 12:3 (DM)-B looked at R	rint date 3/31/16, identified R85 electrolyte imbalance related to restriction with interventions of peech therapy services, on xtures and nectar thick for free water between meals. radequate intake related to loss noted since admission, and intake with interventions protein kcal, with nectar liquids. Iders, dated 3/7/16, identified rotein, high calorie diet, atture and patient okay for free in water between meals. In water between meals.	F 2	282	application. Skin integrity task in Point of Care in Click Care has been initiated to aut populate for all residents, to captur skin issues, document by Nursing Assistants, with prompt to report to Re-education to all nursing staff on importance of skin integrity observate reporting and follow-up documentate. Audit to be completed by DON or designee, and Nurse Managers two each week for three months. Results he reviewed by QAPI team.	Nurse. ation, tion.		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SECONDS - CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	glass (240 cc) of red DM-B stated R85 will 30 minutes before room between mean have nectar thickers stated the staff should from the table whe Con 3/31/16, at 9:44 dietary sheets were plan. On 3/31/16, at 1:42 (DON) stated that whave regular water have regular water R85's care plan an LACK OF MONITO CARE PLAN: R86's plan of care	age 21 DM-B then removed the full egular water from the table. was able to have regular water or after meals and in R85's als. DM-B stated R85 was to ned liquids during meals. DM-B ould have removed the water in R85 was served her meal. A a.m., the DM-B stated the expart of the residents care DR.M., the director of nursing would be wrong for R85 to at meal time and R85 should between meals if that is what diphysician orders indicate. DRING SKIN STATUS PER dated 10/1014 instructed staff in with cares and with weekly	F 2	32		
	have a bruises on thands and right an	on 3/28/16, at 4:49 p.m. to the top of his right and left d left forearms with no hese being identified by the				
	after the surveyor k attention of the star note dated 3/31/16 Follow up: Bruising measuring 2 x 1.2 x 2.4 cm, bruising a 2 cm, 4 x 8 cm and	s documentation of bruising brought these bruises to the ff on 3/31/16. The progress indicated, "New Bruise or found on resident left forearm cm [centimeters], 1 x 1.5 cm 3 also found on right elbow 19 x 13 x 1.5 cm. Information on right to light purple in color,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	resident denies an note was another which said, "New I also found on left I x 7 cm, 3 x 2 cm, I On 3/31/2016, at 1 (NA)-C stated resibruises on their bassessment was also stated if we sibruising during daithem up in the mostated she was un at this time. On 03/31/2016, at nursing (DON) stated she was un at this time. On 03/31/2016, at nursing (DON) stated she expected monitor bruises for bath days a full sk by the nurse. The should be looking evening cares and bruising. The DON be looked on a daicare plan instructed with cares and with the staff did not for R86's bruising. The facility Care Prindicated V. [five] of Sources are, but no related to preventive requiring care. VII.	y pain." Following this progress progress note dated 3/31/16 Bruise or Follow up: Bruises mand 1 x 1 cm [centimeters], 8 right hand 14 x 8 cm." 0:25 a.m. nursing assistant dents' skin was monitored for ath days when a complete skin completed by a nurse. NA-C ee any new concerns with ly cares, when we are washing rning, we alert the nurse. NA-C aware of any bruising on R86	F 2	82		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (X	,	SURVEY PLETED
		245218	B. WING			04/0	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041		
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F 309 SS=E	Resident Care Plar the Plan C. The res and assign care for procedures to cominformation to the results of the Plan C. The results of the Plan C. The resident must provide the necess or maintain the high mental, and psychological plan C. The Plan	eventive measures. XII. [12] In Documentation and Use of sident care plan is used to plan all disciplines. F. Develop municate all care plan esident care staff. CARE/SERVICES FOR	F 2				5/3/16
	and plan of care. This REQUIREMENT by: Based on observative, the facility f (R125) who receive care plan to direct of staff were trained in coordinate care with addition the facility related skin concerneviewed for skin; on the comprehens residents (R86) revisedents (R86) reviservices; failed to id 1 of 4 residents (R86) reviservices; failed t	NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 resident ad dialysis services, had initial dialysis care, failed to ensure a dialysis cares and failed to the the dialysis center; in failed to identify non-pressure as for 1 of 4 residents (R86) failed to identify missing teeth sive oral assessment for 1 of 3 riewed for dental status and dentify and monitor bruising for 68) reviewed for skin; failed to to indition for 1 of 4 residents skin condition; failed to follow to obtain a lab value for 1 of 1			R 125 has been discharged from factor on 3/23/16. Policy and procedure for residents receiving dialysis will be reviewed and revised. An initial care plan was developed in electronic healthy record to be utilized individualized upon admission to facil immediate dialysis cares. Nursing state 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 for future admissions and will be	the dand dilitate taff to	

				OATE SURVEY OMPLETED		
		245218	B. WING _	·····	04/	01/2016
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F 309	Findings include: LACK OF INITIAL INTERVENTIONS STATUS: Although R125 wa and had received to admission to the factorial admission of care center and facility dialysis as follows: R125 was admitted chronic kidney disadmission record. R125's admission identified R125 was renal diet and fisture and Saturdays and revealed the dialys located in the front observations at this uncovered, clean and the sure bruit is thrill felt with palpa shift. Document review assessment/interir	CARE PLAN TO ADDRESS DIALYSIS s new to dialysis treatments three treatments since acility, there was no re completed with the dialysis to ensure R125 tolerated d on 3/23/16, with diagnosis of ease according to facility progress note 3/23/16, as alert and oriented, received a la on left arm. n 3/30/16, at 11:35 a.m., R125 alysis on Tuesdays, Thursdays, I had no fluid restriction. R125 as access sight was a fistula to of the left upper arm. During s time the fistula site was	F 30	completed upon dialysis admiss DON or designee. Results will reviewed by QAPI team. Resident R61 passed away on R86 and R68 skin integrity task initialized for documentation of sintegrity every shift in the point of application. A new Skin integrity assessment developed and R86 and R68 with completed with new assessment plans reviewed and revised as in Skin integrity task in Point of Carolick Care has been initiated to populate for all residents, to capskin issues, document by Nursing Assistants, with prompt to report Nursing staff to be trained on supprocess. Audit to be completed by DON of designee, and Nurse Managers each week for three months. Research week for three months. Research week for three months. Research week for three months. Results will also be educated to put in the chart posting sending to Physician/FNP. Audit to be completed by DON of designee one time each week for months. Results will be reviewed the months and months are reviewed the months and months are reviewed to the months and months are reviewed to	d/5/16. has been skin of care t has been lhave it. Care in Point auto outure noted in auto outure noted in auto outure in the it. Nursing it FYI faxes or three in the outure of the lates of lates	

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04/	01/2016	
_	PROVIDER OR SUPPLIER	EM - LAKE CITY	:	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041		.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	care interventions a complications and/ needs, special nutrisks for adverse maccess site, infection measures, monitor other monitoring reand after dialysis trigiving medications removing medications removing medications removing medications removing medications removing interview or registered nurse (Freceived fluid restrict know what to do for dialysis. RN-A state would apply pressured nursing assistant (I hall. NA-A stated raccess site, and if call nurse. NA-A stated raccess site, and if call nurse. NA-A stated raccess site, and if call nurse. NA-A stated raccess site, and if call nurse in the call stated not aware of know if fluids were. During interview or looked at R125's trict (TAR) and stated the for nurse to monito making sure the bristethoscope and the states of the complete states o	cked evidence of any dialysis such as: risk factors, potential or specific dialysis related care itional and fluid volume needs, edication effects, care of the on control measures, skin care ing of vital signs, weights and quirements, such as before eatments, instructions for (to prevent dialysis treatments on from the resident's system), etween the facility and dialysis address the "Do Not and advance directives." 13/30/16, at 11:41 a.m., IN)-A stated not aware if R125 iction. RN-A stated did not r R125 when returned from ad if bleeding at fistula site, are and call charge nurse. 13/30/16, at 11:50 a.m., NA)-A stated worked on R125's not aware of location of dialysis obleeding at site NA-A would ated R125 was a new ed for R125 one day, and was sis the following day. NA-A any special diet and did not	F 309	Nursing staff to be educated on assessment Audit to be completed by Nurse two times each week for three in R77 care plan has been review revised as indicated. Lab policy has been revised. HUCs/Nursing will be re-educated system for lab orders and revise policy. Audit to be completed by Nurse two times each week for 3 mon Results will be reviewed by QAI	Managers months. ed and sed on ed lab Mangers Mangers ths.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245218	B. WING _		04	/01/2016	
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP C 500 WEST GRANT STREET LAKE CITY, MN 55041		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 309	already completed morning. During ir stated had observe monitored the bruit a LPN-A stated they for bruit and thrill. another nurse and During interview or verified was assign NA-B stated not avaccess sight and drestriction. During interview or stated the nurse w cares for the day nand communicated nursing assistants dialysis. RN-B stated sassistants to provid assistant kardex in that time, RN-B ve R125 voided 1-2 time left arm, and dainursing assistant kardex in the dialysis port sit diet, fluids, and embleeding at dialysis the nurse. RN-B s visits since admission communication rep RN-B stated R125 RN-B stated medicordered and not away were to be held pri	practical nurse-A (LPN-A) had bruit and thrill check for that atterview at that time, LPN-A and the dialysis port and had not and thrill. When asked to and thrill check, RN-A and did not know how to monitor LPN-A stated would get left the floor. 1. 3/30/16, at 1:18 p.m.,NA-B and to R125's hallway that day. Ware of location of dialysis id not know if received fluid 1. 3/30/16, at 1:20 p.m., RN-B and the calendar and dialysis appointments to who care for R125 on days of the dexpected nursing decare according to nursing facility computer system. At a rified the kardex identified the kardex identified the ardex lacked identification of the care of dialysis resident, are gency care. RN-B stated, if a port sight, staff knew to get tated R125 had three dialysis	F 30	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245218	B. WING		····	04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	REET ADDRESS, CITY, STATE, ZIP CODE O WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG			ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	/interim care plan d diagnosis of renal in identification of dial	ated 3/23/16, indicated nsufficiency, and no	F 3	09			
	of nursing stated sh	ne expected dialysis resident ialysis needs identified.					
	Document review of facility Care of Dialysis Resident policy review date of 1/2016, revealed the following:						
	after dialysis will oc record will be used treatment and giver staff after treatmen communication rec addressed comprel care, the policy did care plan. IDENTIFICATION A	ent communication before and cur. A dialysis treatment by the dialysis provider during in to the skilled nursing facility it as a summary and ord. Although the policy nensive care plan for dialysis not address initial dialysis AND MONITORING OF NON FED SKIN CONCERNS:					
	have a bruises on t hands and right and documentation of the	on 3/28/16, at 4:49 p.m. to he top of his right and left d left forearms with no nese being found until the staff em by this surveyor on					
		cian orders included ive 5 mg (milligrams) by ng for joint pain.					
	3/21/16, 3/14/16 an	ath forms dated 3/28/16, d 3/7/16 did not identify any of R86's hands or forearms.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	"New Bruise or Foll resident left forearr [centimeters], 1 x also found on right 3 x 1.5 cm. Informato light purple in co. R86's progress not "New Bruise or Foll left hand 1 x 1 cm cm, right hand 14 x R86's plan of care to, "monitor my skin bath." On 3/31/2016, at 10 (NA)-C stated reside bruises on their batassessment was coalso stated if we see bruising during dail them up in the mor stated she was unatothis time. On 03/31/2016, at nursing stated there medical record regarms or hands. The staff to document at The DON stated or assessment was con DON stated nursing at skin during morn notify the nurse of a staff to notify the nurse of a	re dated 3/31/16 indicated, low up: Bruising found on m measuring 2 x 1.2 cm 1.5 cm 3 x 2.4 cm, bruising elbow 19 x 2 cm, 4 x 8 cm and ation on Bruise: Bruising purple lor, resident denies any pain." re dated 3/31/16 indicated, low up: Bruises also found on [centimeters], 8 x 7 cm, 3 x 2	F3	809			

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	` '	E SURVEY IPLETED
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		500	REET ADDRESS, CITY, STATE, ZIP CODE O WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 29	F 3	09			
		dure for monitoring non in conditions was requested					
	ASSESSMENT AN INTERVENTIONS	EHENSIVE DENTAL D DEVELOPMENT OF BASED ON THIS MEET THE NEEDS OF THE					
	R86 was observed	on 3/28/2016, at 4:52 p.m. to be missing one tooth on top th and one tooth missing on e of his mouth.					
		nent dated 2/24/16, did not ssing teeth or any dental					
		rised 12/9/15, did not identify eth or any dental concerns.					
	nursing (DON) stated dental assessment did not missing teeth for co DON stated she exteeth in the oral assecuted indicate miss section of the asseschecked R86's oral completed by the fassessments addressessments addresses that according to the DON stated the plan for R86 that according to the testing to t	t have an option to pick ondition of natural teeth. The pected staff to include missing sessment and stated staff ing teeth under the comments ssment. The DON stated she assessments that had been acility and stated none of the essed R86's missing teeth. ere was nothing in the care ddressed missing teeth and ag teeth should have been					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04	/01/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	instructed staff, "A be done on admiss with a significant of a registered nurse of natural and artiff LACK OF IDENTIF OF BRUISING: R68 was observed have two dark purphand and wrist are R68's quarterly Minidentified diagnosis R68's progress no bruising of the right left knee on 12/15/R68's care plan was a problem area relinterventions to proto implement if bruice on 3/30/16, at 11:0 (NA)-H verified R6 hand and wrist are system was the NA nurse when bruisin nurse makes a reponsible of the right hand and were not aware of	dicy with a review date of 1/16, in oral health assessment will sion, annually, quarterly and hange in resident's condition by (RN)Procedure:condition icial teeth" FICATION AND MONITORING I on 3/28/16, at 4:43 p.m., to ble bruises on top of his right a. Inimum Data Set dated 2/17/16, is of anemia. Ites identified R68 had prior to forearm on 6/28/16, and the 15. Ites reviewed and did not include ated to R68's risk for bruising, event bruising, nor interventions ising was identified. I of a.m., nursing assistant 8 had bruising on his right a. NA-H stated the facility As usually report to the charge ing is noted, then the charge	F3	09		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245218	B. WING _		04	/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CO 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	bruising. Then a ris completed, the size documented and the until healed. On 3/30/16, at 11:4 assisted R68 with a stated, when queric concerns or bruising put lotion on R68's notice any skin conthose bruises. On 4/1/16, at 10:40 facility system was the NA notifies the measures the bruisinto risk management after discovery we into place and try to occurred. The DON bruising to be report to be identified on the area, as R68 has head A policy for non-prerequested, but not R61 was observed RN-D to have an an agreat toe that was a color. R61's quarterly Mir 12/30/15, identified R61's care plan, re	It k assessment would be to of the bruise would be to of the bruise would be to of the bruising would be monitored at a.m., NA-I stated she had getting dressed this a.m. NA-I and if R68 had any skin g, R68 had very fragile skin, I arms and shoulders, I did not cerns and R68 always has a a.m., the DON stated the anytime a NA sees a bruise nurse. The nurse then are and enters the information and the anytime and the anytime and enters the information and the angle of the read and enters the information and the stated she would expect the read and would expect the read and would expect bruising he care plan as a problem and bruising before. The surrespond of R61's right dried, hard and dark brown in a simum Data Set dated diagnosis of diabetes. The provided of R61's right dried, hard and dark brown in a simum Data Set dated diagnosis of diabetes.	F 30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		500	EET ADDRESS, CITY, STATE, ZIP CODE WEST GRANT STREET KE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	decreased mobility R61's progress not 3/18/16, incident: s an old blood blister Area does not apped does not wear shoe covered with blank pinched when push meal time. Resider happened. Area me by 1.8 cm. Interven Physician notification R61's record failed the fax prepared. 3/20/16, follow up is resident sustained from his feet hitting wear shoes. He is is happened. Blister a scabbed over. Area No drainage or blee Dx (diagnosis) that type two diabetes. contributed include novolog insulin. 3/20/16, blister is d yellow dry skin on t 3/24/16, blister righ blood under skin. 3/25/16, document cm x 1.2 cm area v hard callous center area.	cation use, venous ular disease, incontinence, and edema. es identified the following: taff found what appears to be on resident's right great toe. ear to be pressure as resident es and does not sleep with feet ets. His toe may have been ning his chair up to the table at it is unaware of what easures 1.7 cm (centimeters) ations: Apply alkare daily. On: fax prepared. However, to include documentation of incident, type of incident: blood blister injury possibly the dinner table. He does not unable to state what area now appears hard and a around toe appears healthy. eding. Will continue to monitor. may have contributed include Rx (medication) that may have metoprolol (beta blocker) and ark red/purple in color. Has op. No drainage. It great toe, dry with dried on blister of right great toe, 2 with dried blood under skin and of the notion of the notion. No discomfort. No open	F3	09			
		ogress note dated 3/24/16, per OON on 3/31/16, at 1:40 p.m					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		3) DATE SURVEY COMPLETED	
		245218	B. WING			04/0	01/2016	
	PROVIDER OR SUPPLIER			50	REET ADDRESS, CITY, STATE, ZIP CODE O WEST GRANT STREET AKE CITY, MN 55041	,	.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 309	R61's record failed notification of R61's change in condition included a diagnos. On 3/30/16, at 1:2's know if the area or pressure area or not know if the area whad completed the not measured it. Results the treatment would administration record for the nurse to may would appear in Results of the blister located. The facility policy (Notification, dated standards: attending to be notified of condition/health standards: attending to be notified of condition/health standards: a weel on call is to be noti	poor foot perfusion. However, to include documentation of sphysician regarding the not R61's right great toe which its and treatment orders. 7 p.m., RN-D stated she did not a R61's right great toe was a ot. RN-D stated she did not as measured weekly and she treatment yesterday and had N-D stated documentation for do be on the treatment ord (TAR) and the TAR allowed ake a progress note, which then 61's progress notes. 9 p.m., the DON verified R61's amentation of R61's physician to change in Skin condition of on R61's right great toe. Change in Condition review date 1/16, indicated and provider or provider on call resident's change in atus. Procedure: 1. Between so or typical wakeful hours, and the attending provider or provider fied of all conditions or health after hours, the attending or on call should be notified of dition, health status or incident to potential for provider Document time of call, provider occument time of call and	F3	309				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245218	B. WING			04/0	01/2016	
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTE	EM - LAKE CITY		500 W	T ADDRESS, CITY, STATE, ZIP CODE EST GRANT STREET CITY, MN 55041			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	IN THE TREATMEN NEED: R77's admission rethat the resident hanon-ST elevation (Natheat attack), heart R77's hospital dischadmitted to the hos report summarized EKG changes and a R77's care plan, daresident was at risk cardiovascular statulabs would remain with that R77 obtain lab R77's progress note the resident had ne stated, "Give Lasix decreased the amopo [by mouth] now. BID [twice a day] at 3/5/17. Recheck BN determine if heart fa BMP [a routine block R77's blood chemis indicated that the reaction of the resident had resident had ne stated, "Give Lasix decreased the amopo [by mouth] now. BID [twice a day] at 3/5/17. Recheck BN determine if heart fa BMP [a routine block R77's blood chemis indicated that the reaction of the resident had the resident had the reaction of the resident had the reaction of the resident had the	cord, dated 1/22/16, indicated d diagnoses of: subsequent ISTEMI) myocardial infarction t failure and hypertension. narge summary, dated hat the resident had been pital for a heart attack. The that R77 had been having an elevated troponin. ted 1/23/16, indicated the for alteration in us. A Goal identified were that within normal limits. It advised	F3	09				

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	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, Z 500 WEST GRANT STREET LAKE CITY, MN 55041	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 309	through 3/31/16, die had been complete R77's blood chemis reviewed from 3/5/1 that the BNP had not When interviewed oregistered nurse (R not been done on 3 that the lab had not RN-I checked the chospital and confirm system. When interviewed of health unit coordina BNP had not been HUC-D stated that lab, the HUC would system; once this with the order and confirm stated that it had not when interviewed of director of nursing of should have followed ordered the lab test. Review of the facilit Laboratory Orders The lab values to be provider orders. It of transcribe an order A one-time order with under "other." A HU slip when the lab we see the state of the state	es, reviewed from 3/9/16 d not indicate that the BNP d as ordered. Stry report, dated 3/4/16 6 through 3/23/16, indicated of been done. On 3/31/16 at 10:34 a.m., N)-I stated that the BNP had /9/16 as ordered. RN-I stated been done at all since 3/4/16. omputer system from the ned that the lab was not in the on 3/31/16 at 10:37 a.m., ator (HUC)-D stated that the once the physician ordered a then place it in the computer was done a nurse would check on that it was in place. HUC-D of been done in this case. On 4/1/16 at 12:58 p.m., the DON) stated that the staffed the physician's orders and	F3	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	M - LAKE CITY	5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	,	
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F 309 F 323 SS=E	Continued From pa phone. 483.25(h) FREE OF HAZARDS/SUPER	- ACCIDENT	F 309			5/3/16
	environment remain as is possible; and	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to				
	by: Based on interview facility failed to come determine if resider unattended in the waresidents (R31, R7, accidents. Findings Include: R31's care plan date made the determination unsupervised in a ware included death; "I was benefits such as sligunsupervised causi will be reviewed quartended to intellectual function impaired memory, jund thought process cognitive abilities in unsupervised bathin identified R31 to ha	and document review, the plete an assessment to ats were safe to be left chirlpool bathtub for 4 of 4 R25 and R90) reviewed for ed 6/23/16 indicated R31 had ation to bathe (soak) chirlpool bathtub and identified along in the tub while and injury or death, My decision arterly." R31's plan of care for staff of "chronic decline in ing" related to stroke that udgment, decision making, sing; conflicted with R31's dicated in the plan of care for ag. In addition, the care plan we a history of stroke that (inability to speak or		Careplans updated on R31, R7, R R 90. Education added to precepting she all new nursing staff. Education done with all Nursing Stathe bathing process of ensuring all residents will not be left unattended whirl pool tub. Audit completed by Hall Nurse thre each week for 3 months. Results were reviewed by QAPI team.	eets for aff on d in the	

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F 323	understand langua injury) and paralysi The dressing/bathi care conflicted with directed staff to giv of 1." and informed extensive assistance impairment, decreating impairment, decreating air of mobility of R31's quarterly Mir 12/30/15 indicated have moderately infor daily living, iden long-term memory extensive physical for transfers and be included diagnoses paralysis, diabetes one eye, major depatrial fibrillation, art joints), and osteopor R31's record did not assessment to detect cognitive abilities to unsupervised that irisks and interventing R31's record did not completed analysis bathe unsupervised predisposing factor impaired speech, unability. On 3/30/16, 8:35 a stated she did not to leave R31 alone in stated she did not current. RN-B states she was not as ale	ge related to disease or brain s of the right side of her body. ng/personal hygiene plan of a the unsupervised bathing and re "weekly tub bath with assist I staff, "resident needs ce related to: cognitive ased physical functioning, and f lower extremities." nimum Data Set (MDS) dated the staff assessed R31 to a npaired decision-making skills atified R31 to have short and problems, and required assist from two staff members athing. The facility face sheet is of stroke with one sided type II, aphasia, blindness in pressive disorder, heart failure, thropathy (inflammation of	F 32	3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245218	B. WING		04/	01/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 38	F 3	23		
	determine if R31 w bathtub unsupervis and benefits should conferences notes On 3/30/2016, at 1 would not be able to want to be left in the nonverbal and state was identified by the appropriate candidate bathtub unsupervis were no safety assistants as wantibathtub alone unsuratione in the bathtub based on resident of nursing assistance assessments/evaluate by a trained license stated if an assess for safety, R31 would not be stated if an assess for safety, R31 would not be stated in the whirlpool bath were supposed to requarterly basis at corfamily members aware there was not progress notes to it were reviewed at the for R31. The DON	essment completed to as safe to be in the whirlpool ed. RN-B stated review of risk d be documented in the care on a quarterly basis. 18 p.m. the DON stated R31 o communicate she would e bathtub, as she was ed she was not sure how R31 e nursing assistants as an ate to be left alone in the ed. The DON stated there essments completed to sidents identified by the nursing ng to soak longer in the apervised were safe to be to, the decisions were just choice. (*Note: It is not within a scope of practice to perform lations for any resident care determinations; lations can only be performed and staff member.) The DON ment would have been done all have never have been dent that could be left e bathtub. The DON stated safe to be left alone in the led and confirmed the care could leave R31 unsupervised htub. The DON stated staff review risk and benefits on a lare conferences with residents. The DON stated she was a documentation in the endicate the risk or benefits he quarterly care conferences stated, "On a positive note at one to find this and we did not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED			
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		500	REET ADDRESS, CITY, STATE, ZIP CODE WEST GRANT STREET KE CITY, MN 55041	,	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	have a resident dro An environmental of with the call light play rooms. On 4/1/16, at the call light cords if were not long enous either tub room and something else for were looking at get verified there was re tub for resident accord R7's care plan with indicated R7 had me bathe (soak) unsup and identified R7 had potential risk: "Risk stay in bathtub with I will be aware of rist decision will be revicate for cognition in loss" related to sho remembering, unab unable to communi need assistance with history of stroke, co abilities indicated in unsupervised bathi identified R7 to hav resulted in aphasia understand languag injury) and paralysis The dressing/bathin care conflicted with directed staff to giv extensive assist of R7's annual Minimu 12/28/15, identified	concern was also identified accement in the whirlpool tub at 9:20 a.m. the DON stated in both whirlpool tub rooms gh for residents' to use in a the facility needed to do a call light and stated they ting a longer cord. The DON no way to fasten the cord to the ress and use. The acceptance of 5/3/15, and the determination to be revised in a whirlpool bathtub and an awareness of the and Benefit forchoosing to a staff not in attendance. Goal: sks and benefits and my iewed quarterly." R7's plan of a formed staff of "cognitive ort term memory loss, difficulty ble to reason, make decisions, cate needs effectively and the daily decisions related to conflicted with R31's cognitive in the plan of care for an and the interpretation of the care plan are a history of stroke that (inability to speak or ge related to disease or brain as of the right side of her body. In addition, the care plan are a history of stroke that (inability to speak or ge related to disease or brain as of the right side of her body. In addition, the care plan of the unsupervised bathing and e "weekly tub bath with	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04	/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP 500 WEST GRANT STREET LAKE CITY, MN 55041	•	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 323	cognitive impairmer required extensive members for transf face sheet included sided paralysis, aph dementia with beha R7's record did not assessment to detecognitive abilities to unsupervised that is risks and intervention R7's record did not completed analysis bathe unsupervised predisposing factor impaired speech, mimpairment. On 3/30/2016, at 1: stated there was not completed to determinate the determinate of the wind stated if an assess for safety, R7 would resident that could whirlpool bathtub. The safe to be left all unsupervised and confiderence the facing conference in place of the particular risk and be conference to be left unsupervised. The DOI particular risk and be conference the facing conference the facing conference the facing conference the facing conference in place of the particular risk and be conference to be left unsupervised. The DOI particular risk and be conference the facing conference the facing conference in place of the particular risk and be conference to be left unsupervised. The DOI particular risk and be conference the facing conference in place of the particular risk and be conference to be left unsupervised. The DOI particular risk and be conference the facing conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk and be conference in place of the particular risk	ont, unclear speech, and physical assist from two staff ers and bathing. The facility I diagnoses of stroke with one hasia, Alzheimer's disease, aviors, and anxiety. I diagnoses of stroke with one hasia, Alzheimer's disease, aviors, and anxiety. I reflect a comprehensive ermine R7's physical and bathe (soak) in a tub dentified the potential safety ons to decrease the risks. I reflect evidence of a strong to determine risk level to diseased off the assessed is identified on the MDS of hobility and severe cognitive. 18 p.m. the director of nursing of a safety assessment mine if R7 was safe to be left whirlpool bathtub. The DON ment would have been done do not have been identified as a be left unsupervised in the late the DON stated R7 would not one in the bathtub confirmed the care pland deleave R7 unsupervised in the stated staff were supposed to be left on a quarterly basis at with resident or family N stated when reviewing this penefit form at care lity was reviewing resident attended in the whirlpool	F3	323		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04	/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP C 500 WEST GRANT STREET LAKE CITY, MN 55041	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	comprehensive assidetermine if a residunattended in the wistated R7 should have wanted to be left alunattended because condition since have R25's Risks and Be R25 had made the unsupervised in a wight R25 had an awarer included death. R25 informed staff of peand diagnoses of dia	eessment completed to ent was safe to be left whirlpool bathtub. The DON ave never been asked if she one to soak in the whirlpool e of her current physical ing the stroke. enefits dated 5/13/15, indicated determination to bathe (soak) whirlpool bathtub and identified ness of the potential risk that 5's plan of care for cognition ementia. The ersonal hygiene plan of care unsupervised bathing and e " limited assist with bathing." lan informed staff, R25 assist with a gait belt for ated R25's transfers fluctuated in the case that were R25 to be left unattended in the imum Data Set (MDS) dated R25 required extensive assist sfers, total dependence for on physical assist, and a brief I status score of 6, which agnitive impairment. The facility I diagnoses of transient A-strokes), major depressive	F3	23		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	COMPLETED		
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	R25's record did not completed analysis bathe unsupervised predisposing factor impaired mobility at impairment. On 3/30/2016, at 1: (DON) stated there completed to determinate determinate of the with stated R25 had derivated R26 had not have to be left unsupervibathtub. R90's risks and bein R90 had made the unsupervised in a wind R90 had an awarer included death. R90 informed staff of conflicted with the undirected staff to R9 groom/bathe/dress extensive assistance mobility care plan in extensive from staff did not address the completed to allow the whirlpool bathture R90's significant che (MDS) dated 2/1/16 predictions and significant che (MDS) d	to determine risk level to determine d		323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04	/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	indicated severe co extensive assist of of one for bathing, diagnoses of heart impairment. R90's record did no assessment to detecognitive abilities to unsupervised that is risks and intervention R90's record did no completed analysis bathe unsupervised predisposing factors impaired mobility arimpairment. On 3/30/2016, at 1: (NA)-F stated R90 I and stated she had whirlpool bathtub to back or had left her come right back. No her alone for very lobecause something On 3/30/2016, at 1: (DON) stated there completed to determinattended in the with stated she did not he being left alone in the unsupervised and sand an assessment to determine if R90 in the whirlpool bath were no parameters.	gnitive impairment, required two staff for transfers, assist The facility face sheet included failure, and mild cognitive at reflect a comprehensive ermine R90's physical and bathe (soak) in a tub dentified the potential safety ons to decrease the risks. It reflect evidence of a to determine risk level to a based off the assessed identified on the MDS of	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245218	B. WING		····	04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		50	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	safety and none pro	sted in regards to resident ovided. RMACEUTICAL SVC -	F 3				5/3/16
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personn	ovide routine and emergency als to its residents, or obtain eement described in eart. The facility may permit nel to administer drugs if State by under the general ensed 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.						
	a licensed pharmad	nploy or obtain the services of sist who provides consultation e provision of pharmacy ity.					
	by: Based on observative review, the facility fuberculin solution is resulted in the admituberculin for 1 of 1. Findings include:	NT is not met as evidenced tion, interview, and document ailed to properly discard a n a timely manner which inistration of expired resident(R127) reviewed.			All tubersol supply has been check expiration dates. When tubersol is opened, sticker to date opened and date expired to be placed at time of opening. Performance discussion completed nurse on checking for expiration datuberculin solution. Nurses to be educated on checking	state e with te of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		5	TREET ADDRESS, CITY, STATE, ZIP CODE 600 WEST GRANT STREET LAKE CITY, MN 55041	1	· // <u>-</u> · // -
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)) BE	(X5) COMPLETION DATE
F 425	the admission form R127's physician or that the resident ha Solution (Tuberculir ml (milliliters) intrad 1 of a 2 step Manto derivative. R127's medication dated 3/29/16, indicated 3/29/16, indicated the ordered the ordered that the solution of C4864A. 1/12/2018. It was a forearm. However, opened on 2/23/16 days or by 3/24/16. When interviewed or registered nurse (R resident had been a solution after 3/24/1 (R127). RN-C state checked the opened solution every time when interviewed of the checked the opened on the checked the opened of the checked the opened on the checked the opened of the checked the opened on the checked the opene	_	F	125	expiration dates for all medications Tuberculin solution expires 30 day date of opening which is written or tuberculin solution. Nursing educa place sticker on at time of opening date opened and date expired. Audits to be completed by Night Course one time weekly for 3 month Results will be reviewed by QAPI to	s from ted to with harge	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04/	/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 425	solution (no date), o	ige 46 rivative (Mantoux) Tubersol directed that a vial of Tubersol use for thirty days should be	F 4	25		
F 431 SS=D	information for Tub 483.60(b), (d), (e) [F 4	31		5/3/16
	a licensed pharmac of records of receip controlled drugs in accurate reconcilia records are in orde	inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically				
	labeled in accordar professional princip appropriate access	als used in the facility must be nee with currently accepted ples, and include the ory and cautionary e expiration date when				
	facility must store a locked compartmen	State and Federal laws, the all drugs and biologicals in the nts under proper temperature it only authorized personnel to keys.				
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		245218	B. WING		04/01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTI
F 431	quantity stored is m be readily detected	bution systems in which the ninimal and a missing dose can	F 43	1	
	Based on observareview, the facility f were labeled according to 25 medications radministration. This R72, R107).	tion, interview and document ailed to ensure medications ding to physician's orders for 3 eviewed during medication a affected 3 of 8 residents (R7,	Medications for R7, R72, and been checked for proper laber of change in direction sticker. All medications have been chassure they are labeled accomphysician orders or a change sticker has been applied. Nursing staff to be educated		and use blied. ed to to rection
	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.			of Medication Administration, which includes monitoring all meds for addispensing labels. Consultant Pharmacy Nurse and Manager will complete weekly audmedication carts for three months. Results will be reviewed by QAPI to	h ccurate Nurse lits on
	that the resident wa	ers, dated 2/17/16, instructed as to receive lubricant eye n each eye at bedtime.			
	stated that the labe was incorrect. RN-I procedure when an physician was to pu sticker on the medi	on 3/28/16 at 6:42 p.m., RN-F I on the lubricant eye ointment stated that the correct order had changed by the ut a "change of directions" cation which indicated that the . That would notify the nursing			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245218	B. WING			04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY		500	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	R72 was observed administration on 3 administered 0.5 m antianxiety medicat medication instruct four times a day an treatment. R72's admission reindicated that the regeneralized anxiety R72's physician orditat the resident was four times a day. R72's medication a from 3/1/16 through resident had receive physician. When interviewed of licensed practical in label on R72's Ativated that the orders had when an order was also notified so when it would have the control of the medication on 3 administered 1000 label on the medication of the medication on the medication of the medication on the medication of the medicatio	during a medication /30/16 at 1:41 p.m., RN-J g (milligrams) of Ativan (antion) to R72. The label on the ed to administer Ativan 0.5 mg d as needed 1/2 hour prior to ecord, dated 12/11/13, esident had a diagnosis of	F 4	31			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245218	B. WING			04/01/2016	
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTE	EM - LAKE CITY		5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET .AKE CITY, MN 55041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 431	R107's admission rindicated the reside fracture of the first. R107's physician or indicated that the resident refused from 3/1/2 that the resident refused from two times a. When interviewed a stated that the labe incorrect. RN-H staneeded a "change in order to indicate was different from a medication package" change of direction. When interviewed a direction when interviewed a different from a medication package in order to indicate was different from a medication package. The DON should have placed on the medications differing order from package. The DON should be notified in changed on future a Review of the policing. Review of the policing medication (1/16)," was responsible for dosage schedule of the first fraction of the policing medication (1/16)," was responsible for dosage schedule of the policing medication (1/16),"	greater than 5 on a 0 to 10 the most excruciating. ecord, dated 10/15/15, ent had a diagnosis of a thoracic vertebra. rders, dated 10/20/15, esident had an order for administration record, 16 through 3/31/16, indicated ceived Tylenol 1000 mg by day for pain. on 3/31/16 at 8:35 a.m., RN-H I on the Tylenol for R107 was ted that the medication packet of direction" sticker affixed to it to the nursing staff the order what was written on the e. RN-H then did place a n" sticker on the medication. on 4/1/16 at 12:45 p.m., the (DON) stated that the staff I "change of direction" stickers to indicate that there was a the instructions on the I stated that the pharmacy n order to get the instructions	F4	131			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04/	01/2016
	OVIDER OR SUPPLIER	EM - LAKE CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		JLD BE	(X5) COMPLETION DATE
() () () () () () () () () ()	container was mark ndicated a recent of use of the medication question the dosagonurse was to check	container. If the medication sed with a label which change in the directions for the on or there was any reason to be or the dosage interval, the	F 4	131		
F 441 4 SS=F S S S=F S S S S S S S S S S S S S	nurse was to check the provider's orders for clarifications. 483.65 INFECTION CONTROL, PREVENT		F 4	141		5/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	LE CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED		
		245218	B. WING		04/01/2016	
	PROVIDER OR SUPPLIER	EM - LAKE CITY	Ę	STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 441	professional practic (c) Linens Personnel must ha transport linens so infection.	ndle, store, process and as to prevent the spread of	F 441			
	by: Based on observareview, the facility infection control preprineal cares for for urinary catheter and analysis of infection affect all resider addition, the facility eye drops for 1 of eye drop medication. Findings include: CATHETER AND FOR STATE AND FOR WASHED AND FOR WASHED AND FOR WASHED AND FOR STATE	tion, interview, and document failed to ensure proper actices for catheter and of 3 residents (R68) reviewed of 4 residents (R7) who received of 5 residents (R7) who received of 5 residents (R7) who received of 6 residents (R7) who received of		Policies were reviewed on Perineal ca 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 the administration of eye drops and ointments. Audits by Consultant Pharmacy nurse Nurse Managers will be done one times 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 document surveillance and analysis of infections. Education nurse updated he spread sheet of infections to include	ch n. with and e a e to	
	R68's catheter dra gloves. Immediate	ainer (to be used to clean inage bag) and removed ly following this observation hing hands placed R68's		analysis and implemented a map to document surveillance. Audit to be completed weekly by DON designee for three months. Results w		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		245218	B. WING			04/0	01/2016	
	PROVIDER OR SUPPLIER	EM - LAKE CITY		5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ION SHOULD BE HE APPROPRIATE		
F 441	located in the bathrodirty gloves she had catheter bag, which NA-G then applied into the bathroom. I gloves, removed R6 NA-G stated had be NA-G placed the se of R68's catheter basin out of R68's rethe basin out of R68's rethe basin into the basin out of R68's remove his pajama washcloth to wash same soiled gloves perineal catheter sit to cleanse the perin R68's catheter drain can. NA-G then with picked up a sterile be clean syringe/container in R68's catheter drain R68's catheter drain R68's room door, we the hallway and obte cloth and towel from walked back into R6 with hand sanitizer, and wash hands after the sanitation of the sanitat	lag inside of a garbage can oom. NA-G then placed the diremoved on top of the was laid in the garbage can. R68's shoes and walked R68 NA-G then donned clean 68's incontinent product, which owel movement on the pad. Siled incontinent product on top ag laid in the garbage can. Soiled gloves grabbed a wash from a cupboard, placed athroom sink, opened R68's a clean incontinent product with putting on the clean. NA-G then with the same R68's clothes, assisted R68 to s and handed R68 a his face. NA-G then with the on cleansed around R68's te and laid the washrag used heal catheter site on top of nage bag laid in the garbage on the same soiled gloves on cottle of normal saline and the iner and placed them back emoved the soiled gloves,	F	141	be reviewed by QAPI team.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245218	B. WING			04/0	1/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S' 500 WEST GRANT STREE LAKE CITY, MN 55041	ΕT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD E ED TO THE APPROPRI FICIENCY)		(X5) COMPLETION DATE
F 441	was observed to d to stand and wash cloth. NA-G then we pulled up R68' part back to bedside at NA-G then remove wash basin, dried towel and disposed garbage can on to bag. NA-G failed to hands after cleans without washing has obtained R68's too proceeded to brus with the same glowincontinent product the garbage, and plastic bags. NA-G removed R68's car garbage can and produce the garbage can and produced the garbage ca	age 53 a provide R68 with cares and onn clean gloves, assisted R68 ed R68's buttocks with a wash with the same soiled gloves on its and assisted R68 to walk and sit down on R68's bed. Ed gloves, emptied out R68's the wash basin out with a paper of the paper towel into the pof R68's catheter drainage or remove gloves and wash ing R68's buttocks. NA-G then ands, donned clean gloves and withbrush, toothpaste and h R68's dentures. NA-G then are soiled wash cloth from placed the items in separate at then with the same gloves on theter drainage bag from the proceed to rinse the catheter wo times using the clean mer NA-G had filled with normal placed the catheter bag into a cen put the bag containing the R68's night stand drawer. NA-G res, opened the privacy curtain so NA-G filed to remove gloves after cleansing a urinary ailed to ensure R68's had a sinage bag after having placed and ge bag into a garbage can. 2 a.m., NA-G was interviewed and any current infections	F 4	.41			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245218	B. WING		 	04/	01/2016	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				500 W	T ADDRESS, CITY, STATE, ZIP CODE EST GRANT STREET CITY, MN 55041			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 441	R68's medication a 3/16, identified R68 (antibiotic) DS (dou (milligrams) one tal infection for 10 day 3/26/16, identified r times daily for 10 d urinary tract infection. On 3/31/16, at 1:22 verified R68 was be and had MRSA inferexpect gloves to be after changing cath around the perinear cleansing buttocks a new catheter bag that had been laid in the common of the catheter bags, after site, after cleansing soiled incontinent property would expect staff of drainage bag in the catheter. 12. Store in bedside stand with the catheter and with the catheter and the catheter. 12. Store in bedside stand with the catheter and the catheter and the catheter. 12. Store in bedside stand with the catheter and the catheter and the catheter. 12. Store in bedside stand with the catheter and the	dministration record, dated was receiving Bactrim able strength) 800-160 mg ablet two times a day for s. R68's progress note, dated new order: Bactrim DS one two ays and the reason was for any MRSA. It p.m., registered nurse (RN)-C eing treated with an antibiotic ection. RN-C stated she would be removed and hands washed neter bags, after cleansing I catheter site and after a RN-C stated she would want to replace the catheter bag	F4	41				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
	245218		B. WING		04	04/01/2016		
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CO 500 WEST GRANT STREET LAKE CITY, MN 55041	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE		
F 441	1/16, indicated produce area with soap and 11. Anchor catheter Remove gloves and The facility policy H indicated proper haprevent spread of demployee and their Washing is done: bequipment, dressing removal of gloves. LACK OF A FUNCT PROGRAM WHICH SURVEILLANCE A The facility Monthly Control Reports we through 2/2016. The infections were indi 4/15, seven urinary respiratory, two skir 5/15, four UTI's, five 6/15, five UTI's, through 15, eight UTI's, through 15, eight UTI's, through 16, five UTI's, through 16, five UTI's, through 17, four UTI's, through 17, five UTI's, or 12/15, four UTI's,	oley Catheter Care, dated bedure: 7. Cleanse perineal water. 10. Dry perineal area. To thigh with catheter strap. It wash hands. and Washing, dated 3/16, and washing is the best way to disease. It protects both the esident. Procedure: 1. Hand. After handling contaminated gs, soiled linen, etc. g. after TIONING INFECTION HINCLUDES ND ANALYSIS: Infection Prevention and are obtained from 4/2015 are following information of cated on the monthly reports: tract infections (UTI's), four the respiratory, two skin are respiratory, two skin are respiratory, two skin, one aree respiratory, three skin are respiratory.	F 4	.41				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245218	B. WING			04/0	01/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
F 441	analysis of the inforprecautions used to infection. On 3/31/16, at 1:04 documentation of sabove information. hand hygiene and purses and nursing increased audits or peri-cares. The facility policy Ir Control Program, unfection Prevention with overseeing the This committee is rand facility wide Quantification, control within the facility. To oversight, review an infection control procompliance to qual standards. III. Infection infection control procompliance of data reporting process of the infection control surveillance of data reporting processes infection control surveillance data collection on racility, as means for the surveillance data control activities and The process 2. Recreporting of the case reporting of	and reporting of infection program. The infection prevention of infection program. The provides guidance of the committee. The provides guidance of the committee (IPC) is charged infection prevention program. The provides guidance of the provides guidance. The provides guidance, the process of the pr	F4	41			

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04	1/01/2016	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP O 500 WEST GRANT STREET LAKE CITY, MN 55041			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 441	this data. LACK OF EYE ME TO PREVENT INF R7's admission rec the resident had a R7's physician orde resident received a both eyes two time The physician orde that R7 received lu was to be instilled i to cataracts. During an observat administration on 3 nurse (RN)-F prepa RN-F knocked on I explained the proce pair of gloves and receive eye drops. artificial tears, and the lower eyelid of touched the tip of t the sclera [the whit and administered or right eye. RN-F did t as well. RN-F ther lubricant eye ointm the procedure to R lowered the lower of administered a ribb lower eyelid. RN-F tube where the me repeated this proce	ontrol efforts are assisted by DICAITON ADMINISTRATION		41			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245218	B. WING		04/01/2016		
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				50	REET ADDRESS, CITY, STATE, ZIP CODE O WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	When interviewed of stated that he might lower lid of the left eye lubricant. When interviewed of stated when admininurse should never of the container. Rowere to have an infoone eye, the infection to the other. When interviewed of director of nursing (who administered the eye lubricant should with the tip of the model of the document of the docu	on 3/28/16 at 6:42 p.m., RN-F thave touched underneath the eye with the tip of the tube of on 3/30/16 at 11:00 a.m., RN-J stering eye medications, the touch the eyeball with the tip N-J stated that if a resident ection (such as pinkeye) in on would spread from one eye on 4/1/16, at 12:43 p.m., the DON) stated that the nurse he eye drops as well as the d not have touched the eye edication containers. The ment titled, "Administering Eye it explained the proper nistering eye medications. It ning the dropper against the	F 4	41			

F5218025

PRINTED: 04/25/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 01 - MAIN BUILDING 01 245218 B. WING 03/29/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **500 WEST GRANT STREET MAYO CLINIC HEALTH SYSTEM - LAKE CITY** LAKE CITY, MN 55041 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

If continuation sheet Page 1 of 4

04/21/2016

Electronically Signed

PRINTED: 04/25/2016 FORM APPROVED OMB NO. 0938-0391

		()		PLE CONSTRUCTION G 01 - Main Building 01	(X3) DATE SURVEY COMPLETED		
		245218	B. WING_		03	/29/2016	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041			23.23.23.13	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUSE FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or possible for corresponsible for correvent a reoccurrent The Mayo Clinic Horiginal built in 19 building and was construction addition was built Type I (332) construction addition was built Type I (332) construction allow facility was survey The facility is fully fire alarm system detection and spamonitored for autonotification. The facility has a census of 83 at the	state.mn.us and an@state.mn.us ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. roposed, completion date. or title of the person rrection and monitoring to rence of the deficiency. Itealth System - Lake City was 77. The facility it is a 1-story determined to be of Type 1 and was determined to be of truction. There is no basement. Because the original building are of the same type of red for existing buildings, the red has one building. sprinklered. The facility has a with full corridor smoke ces open to the corridors that is omatic fire department capacity of 90 beds and had a retime of the survey. at 42 CFR, Subpart 483.70(a) is					

Facility ID: 00770

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADED.			E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245218	B. WING	_		03/2	9/2016
	PROVIDER OR SUPPLIER LINIC HEALTH SYST			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 154 SS=D	Where a required out of service for reperiod, the authoriand the building is watch system is punprotected by the system has been This STANDARD K-154: Where a resystem is out of so a 24-hour period, is notified, and the approved fire watch parties left unprotes.	automatic sprinkler system is more than 4 hours in a 24-hour lity having jurisdiction is notified, a evacuated or an approved fire rovided for all parties left e shutdown until the sprinkler returned to service. 9.7.6.1 is not met as evidenced by: equired automatic sprinkler ervice for more than 4 hours in the authority having jurisdiction e building is evacuated or an ch system is provided for all ected by the shutdown until the has been returned to service.	K	154	A single plan for the out of service for the fire sprinkler was created a in place.	plan	5/3/16
K 155 SS=D	on 03/29/2016, obreviewed revealed plan for the out of sprinkler system. This deficient practically Maintenar discovery. NFPA 101 LIFE S Where a required service for more to the authority having building is evacual provided for all pashutdown until the returned to service This STANDARD	tween 09:#0 AM and 12:30 PM observation and documentation of that there was not a single service plan for the fire ctice was confirmed by the note Director at the time of AFETY CODE STANDARD fire alarm system is out of than 4 hours in a 24-hour period, and jurisdiction is notified, and the ated or an approved fire watch is arties left unprotected by the effire alarm system has been e. 9.6.1.8 is not met as evidenced by: required fire alarm system is out		155	K155 A single plan for the out o	f service	5/3/16

PRINTED: 04/25/2016 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245218	B. WING		03/2	29/2016	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 155	period, the authority and the building is watch is provided for by the shutdown up been returned to so On facility tour between 03/29/2016, observiewed revealed plan for the out of system.	than 4 hours in a 24-hour by having jurisdiction is notified, evacuated or an approved fire for all parties left unprotected intil the fire alarm system has	K 1	·	was created		

Facility ID: 00770



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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Mayo Clinic Health System - Lake City April 13, 2016 Page 2

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

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00770			04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S T GRANT ST	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M-IAKE CIIV	ΓΥ, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deputermination of which corrected requires requirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	p participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf re licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/21/16 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			7. Bollbirta.			
		00770	B. WING		04/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Department of Hearyou electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department on March 28, 29, 3 surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ord they will be completed.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 30, 31, and April 1, 2016 epartment's staff visited the the following correction Please indicate in your orrection that you have ers, and identify the date when	2 000			5/3/16
2 300	Plan of Care; Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The comust include the increquired by Minnes subdivision 14, para This MN Requirements: Based on observation review, the facility for the subdivision of the content of th	of plan of care. The nof care must list measurable stables to meet the resident's mogals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 300	corrected		5/3/16

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00770	B. WING		04/	01/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY 500 WES	DDRESS, CITY, S T GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	Findings include: R111's admission rewas admitted to the R111's admission Mated 11/24/15, ind dental issues. R111 by one staff member R111's quarterly MI resident had any prespecified that R111 by two staff member R111's care plan, defined the resident was unindependently and related to her demer R111's kardex reposassistants on cares 11/18/15, did not corregards to oral care R111's oral exam, or resident had artificity of the time. The resident had artificity of the time.	ecord indicated the resident e facility on 11/18/15. Minimum Data Set (MDS), icated that the resident had no needed extensive assistance er with personal hygiene. DS did not indicate whether the roblems with her teeth. It needed extensive assistance ers with personal hygiene. ated 11/18/15, indicated that hable to groom herself needed extensive assistance entia. art (used to instruct nursing a for each resident), dated ontain any information in				
		ion of cares on 3/31/16 at 7:37 tant (NA)-H assisted the				

Minnesota Department of Health

STATE FORM VG2D11 If continuation sheet 3 of 50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER	FM - LAKE CITY 500 WEST	DRESS, CITY, S F GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	resident with dressi hygiene at this time. When interviewed on ursing assistant (Not dentures. NA-H desa full plate of dentures on the kresident had not be the dentures were proom. NA-H stated the cup with water to NA-H stated that aff the resident's remander NA-H stated that should be the dentures were proom. NA-H stated that aff the resident's remander NA-H stated that should be the dentures were proom. NA-H stated that should have be the dentures were proom. NA-H stated that should have proof to the past. LPN-B stated that the staff cares twice a day. Let the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident if should have proof the past. LPN-B stated that the resident in the past. LPN-B stated that the past. LPN-B stated the past. LPN-B	ng. NA-H did not perform oral				

Minnesota Department of Health

STATE FORM 6899 VG2D11 If continuation sheet 4 of 50

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 560	dentures. R111 wor in the morning and using mouthwash p with pink oral swab wait after R111 had to perform oral care first explain to R111 when performing or having the resident. When interviewed on ursing assistant (N make sure that R11 NA-J would swab F NA-J stated that she while she worked w was afraid to use a resident would bite NA-J stated that whadmitted to the facia a toothbrush when described that R11 toothbrush and not. When interviewed of director of nursing have had an individed her oral hygiene. The information would her oral hygiene. The facility Care Plaindicated V. [five] on Sources are, but no related to preventive requiring care. VII. Individualized care resident. H. List present the summer of the preventive region.	ge 4 uld have her dentures cleaned evening. NA-K described prior to cleaning R111's mouth is. NA-K stated that she would eaten a meal in the morning ies. NA-K stated that she would what she was about to do ral cares in order to avoid potentially strike out at her. on 4/1/16 at 10:18 a.m., NA)-J stated that she would 1's dentures were brushed. R111's mouth with a pink swab. ie would do that every shift with R111. NA-J stated that she toothbrush with R111 as the down and not give it back. In the resident was first lity, she would let the staff use cleaning her teeth; now, NA-J I would only bite down on a let the staff clean her teeth. on 4/1/16 at 12:54 p.m., the (DON) stated that R111 should fualized care plan regarding the DON stated that the lave been put in the Kardex so into would know how to care for an Policy, review date 1/16, oncerns and problems B. It limited to: 8. Problems is e care. 11. All problems [seven] Approach/Plan C. for the unique needs of the eventive measures. IX. [nine] is care plan must be reviewed.	2 560			

Minnesota Department of Health

STATE FORM VG2D11 If continuation sheet 5 of 50

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED	
		00770	B. WING		04/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	and revised (update Resident Care Plar the Plan C. The resand assign care for care plan must be Poevelop procedure information to the results of the Plan C. The resand assign care for care plan must be Poevelop procedure information to the results of the policies/procedures provide and/or reinformation to the results of their quality maintain compliance. Time period of Corrections and results to ensure stap part of their quality maintain compliance.	ed) as necessary. XII. [12] a Documentation and Use of sident care plan is used to plan all disciplines. E. The resident cept current at all times. F. is to communicate all care plan esident care staff. of correction: The director of e) could review and update if needed, force education to staff e facility could perform routine aff are following care plans as assurance program to see.	2 560			
2 565	Plan of Care; Use Subp. 3. Use. A comust be used by al care of the resident This MN Requirements: Based on observative review, the facility for related to diet order reviewed for nutrition follow the care plan cares for 1 of 3 residents.	omprehensive plan of care personnel involved in the ent is not met as evidenced on, interview and document ailed to follow the care plan of sor 1 of 3 residents (R85) on and the facility failed to to observe skin with daily idents (R86) observed to have or non pressure related skin	2 565	Corrected		5/3/16

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY	「GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 6		2 565			
	Findings include:					
	LACK OF FOLLOW	ING CARE PLANNED DIET:				
	has a risk for fluid/e poor intake, nectar discontinue from sp mechanical soft tex consistency, okay f R85 is at risk for ina significant weight lo decreased appetite of high kcal, high po R85's physician ord an order for high pr mechanical soft tex	electrolyte imbalance related to restriction with interventions of beech therapy services, on tures and nectar thick or free water between meals. adequate intake related to ess noted since admission, and intake with interventions rotein kcal, with nectar liquids. Hers, dated 3/7/16, identified otein, high calorie diet, ture and patient okay for free water between meals.				
	sitting in a wheelch the noon meal. R85 centimeters) of regithick orange drink a ensure chocolate d cheese with two pe chowder, a piece of slice of bread. R85 independently. Nur observed to be sittitable assisting anot was encouraging R R85's dietary sheet R85's food, indicate calorie, mechanical On 3/30/16, at 12:2	2 p.m., R85 was observed air at a dining room table for 5 had a 240 cc (cubic ular water, 240 cc of nectar and 120 cc of nectar thick rink, a small bowl of cottage aches on top, hamburger ficed oatmeal cake and a was observed to eat sing assistant (NA)-G was ng at the same dining room ther resident with eating and 85 to eat during the meal. of paper on the table next to ed diet: high protein, high soft, liquid nectar thick.				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTI	HM - I AK H CILLY	T GRANT ST 'Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	On 3/30/16, at 12:2 (DM)-B looked at Fand stated R85 showater at meal time. glass (240 cc) of red DM-B stated R85 where 30 minutes before room between mean have nectar thicker stated the staff showater at the staff showater at the staff showater stated the staff showater showat	age 7 27 p.m., dietary manager 85's dietary sheet on the table buld not have thin [regular] DM-B then removed the full egular water from the table. It was able to have regular water or after meals and in R85's als. DM-B stated R85 was to ned liquids during meals. DM-B uld have removed the water in R85 was served her meal. It a.m., the DM-B stated the expart of the residents care are and R85 should be wrong for R85 to at meal time and R85 should between meals if that is what did physician orders indicate. DRING SKIN STATUS PER dated 10/1014 instructed staff in with cares and with weekly on 3/28/16, at 4:49 p.m. to the top of his right and left dieft forearms with no hese being identified by the standard or resident left forearm component indicated, "New Bruise or found on resident left forearm component indicates," 1 x 1.5 cm 3	2 565			

Minnesota Department of Health

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	GRANT ST Y, MN 5504				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 8	2 565				
	2 cm, 4 x 8 cm and Bruise: Bruising pur resident denies any note was another p which said, "New B also found on left h x 7 cm, 3 x 2 cm, ri On 3/31/2016, at 10 (NA)-C stated resid bruises on their bat assessment was coalso stated if we se bruising during daily them up in the more	also found on right elbow 19 x 3 x 1.5 cm. Information on right to light purple in color, y pain." Following this progress rogress note dated 3/31/16 ruise or Follow up: Bruises and 1 x 1 cm [centimeters], 8 ght hand 14 x 8 cm." 0:25 a.m. nursing assistant lents' skin was monitored for h days when a complete skin impleted by a nurse. NA-C e any new concerns with y cares, when we are washing ning, we alert the nurse. NA-C tware of any bruising on R86					
	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.						

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
		00770	B. WING		04/01/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
MAYO	I INIIO LIE ALTILI OVOTE	500 WES	Γ GRANT ST			
MAYOC	LINIC HEALTH SYSTE	LAKE CITY LAKE CITY	Y, MN 5504	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 9	2 565			
	requiring care. VII. Individualized care resident. H. List pre Resident Care Plan the Plan C. The res and assign care for procedures to cominformation to the resident.	[seven] Approach/Plan C. for the unique needs of the eventive measures. XII. [12] in Documentation and Use of sident care plan is used to plan all disciplines. F. Develop municate all care plan				
	director of nursing of responsible to carry comprehensive car treatments as direct plan. Then to monit	could in-service staff				
	(21) days.					
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			5/3/16
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an am that includes the attending ared nurse with responsibility d other appropriate staff in amined by the resident's needs, practicable, with the resident, the resident's legal a representative at least a seven days of the revision of resident assessment required subpart 3, item B.				
	by:	ent is not met as evidenced ion, interview and document		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00770	B. WING		04/0	1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO CL	INIC HEALTH SYSTE	-M - I AK F (311 Y	T GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	include behaviors for reviewed for behavior plan to include oral (R42) reviewed for revise the care plan for 1 of 4 residents conditions. Findings include: R111's admission reindicated the reside unspecified demendisturbance. R111's quarterly ME that the resident has symptoms directed pushing, scratching sexually) on 1 to 3 of the resident had condepression and disconditional watch for evidence behavior escalates, was safe and to contime. The care pland 3-5 word one-step of R111 was agitated resident up in her coalm assist the resident to her I to the nurses statio warm blanket; it adinteractions between	ailed to revise the care plan to or 1 of 1 resident (R111) iors; failed to revise the care status for 1 of 3 residents dental services and failed to a to include the risk for bruising (R68) reviewed for skin ecord, dated 11/18/15, ent had a diagnosis of tia without behavioral OS, dated 2/22/16, indicated d physical behavioral toward others (hitting, kicking, grabbing, abusing others days in the past 7 days. ated 11/18/15, indicated that gnitive loss due to dementia, orientation. It recommended to of escalation of behaviors. If make sure that the resident me back to R111 at a later recommended using basic commands; it advised when (tossing and turning) have the hair, when the resident was dent back to her bed; when at night, staff were to assist Broda chair at night and bring in addition to offering a	2 570			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	「GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From page 11		2 570			
	that the resident wo recommended to commended the commended to commend the residence of the results of the res	ort (a guide for nursing g for residents), dated 4/1/16, g assistants in regards to any				
	licensed practical n would strike out at a approximately once first the nursing ass to the need to go to determined it was n	on 3/30/16 at 1:34 p.m., urse (LPN)-B stated that R111 staff mostly at night, a week. LPN-B stated that at sistants thought it might be due the bathroom but they not that. LPN-B stated that it dom acts with no rhyme or an out.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER	M. I AKE CITY 500 WEST	ORESS, CITY, S GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	When interviewed of stated that the nurs switch from a toothly had struck out at the R111 had struck out. When interviewed on nursing assistant (Normal of the stated that R111 word doesn't like what you R111 would strike of cares. When interviewed of stated that R111 word doing cares approximately when interviewed of stated that R111 had from 1 to 3 days on physical behaviors were: grabbing, pin RN-G stated this word by the nursing assist no assessment for What would happen the nursing staff word any behaviors. This nursing notes. Nursing chart in the electror (POC). RN-G stated documentation it word would happen the nursing notes. Nursing notes. Nursing notes. RN-G stated documentation it word would happen the nursing notes. Nursing notes. Nursing notes. Nursing notes in the electror (POC). RN-G stated documentation it word word in the stated documentation it word word word in the stated documentation it word word word word word word word word	on 3/31/16 at 9:54 a.m., LPN-B ing assistants would have to orush to an oral swab if R111 e staff. LPN-B stated that it at staff in the past. on 3/31/16 at 10:45 a.m., JA)-K stated that R111 would performing oral cares. NA-K ould strike out at staff "if she out are doing." NA-K stated that ut at staff when doing oral on 4/1/16 at 10:16 a.m., NA-J distrike out at staff. NA-J ould strike out at staff when imately once or twice a week. on 4/1/16 at 12:20 p.m., RN-G diexhibited physical behavior the quarterly MDS. The that this would have included ching, scratching and spitting as documented only one time stants. RN-G stated there was behaviors done on resident's. In, if behaviors were observed, and monitor and document on a would have been in the sing assistants would also nic system called point of care did that if there was any ould be in the nursing notes. at the resident's behaviors	2 570			
	When interviewed of	on 4/1/16 at 12:49 p.m., the DON) stated that the facility				

Minnesota Department of Health

STATE FORM 6899 VG2D11 If continuation sheet 13 of 50

NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY SOW MEST GRARM T STREET LAKE CITY, MN 55041 SAMAMARY STATEMENT OF DEFICIENCIES TAG SOW DEST GRARM T STREET LAKE CITY, MN 55041 PREPRICE (EACH DEFICIENCIES) SOW DEST GRARM T STREET LAKE CITY, MN 55041 PROVIDERS PLAN OF CORRECTION (EACH CORRECTION MISS THE PRECEDED BY FULL EACH DEFICIENCIES) EACH DEFICIENCY OF ILE APPROPRIATE 2 570 Continued From page 13 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 exhibited any behaviors, they 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\(\textit{ [related to] dentures."} \) R42 was observed on 03/31/2016, at 9.43 a.m. in her room, appeared to have no teeth and was not wearing dentures.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MAYO CLINIC HEALTH SYSTEM - LAKE CITY S00 WEST GRANT STREET LAKE CITY, MN 55041			00770	B. WING		04/0	1/2016
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 2570 Continued From page 13 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. Be 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 03/31/2016, at 9:44 a.m. in her room, appeared to have no teeth and was not wearing dentures.			M - I AKE CITY 500 WES	GRANT ST	REET		
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 9:44 a.m. in her room, appeared to have no teeth and was not wearing dentures.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
R42's annual Minimum Data Set Assessment	2 570	should have care plate interventions care puthese behaviors. The did not have an assoresident's behaviors resident exhibited at tell the nurse. Once address the behavior problem" charting for texting where the number on the resident's accomplished weeks. It would the Review of the facility Monitoring/ side effection of the policy stated that the which utilized the data behavior document present), quarterly at stated that the soresponsible for deversident mood and plan. The goal and identified as discuss team (IDT). R42"s care plan data "DENTAL CARE: It r/t [related to] dentuents. R42 was observed her room, appeared wearing dentures.	lanned the behaviors (specific ed that there should be planned which addressed he DON stated that the facility dessment specifically for a sea. She explained that if a any behaviors, they would then or by initiating an "active for two weeks. This was free for two weeks are course of two in be addressed from there. The example of the course of two in be addressed from the target action on admission (if and with a significant change, cial worker, or designee, was beloping and/or updating the behavior sections of the care interventions would be seed in the interdisciplinary The decomposition of the care interventions would be seed in the interdisciplinary The decomposition of the care interventions would be seed in the interdisciplinary The decomposition of the care interventions would be seed in the interdisciplinary The decomposition of the care intervention of the care intervential for impaired res." The decomposition of the care intervention of the care intervential for impaired res." The decomposition of the care intervention of the care intervential for impaired res." The decomposition of the care intervential for impaired res." The decomposition of the care intervention of the	2 570			

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	GRANT ST Y, MN 5504			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 570	Continued From pa	ge 14	2 570			
	(MDS) dated 4/29/1 natural teeth.	5, indicated R42 had no				
	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.					
		nted 10/14/15, indicated R42 h, did not wear dentures and current.				
		nted 4/16/15, indicated R42 h, did not wear dentures.				
	(NA)-C stated she	0:25 a.m. nursing assistant did not think R42 had any d not wear dentures.				
	(DON) stated the o 1/13/16 indicated R did not have dentur plan indicated R42 DON stated R42 did facility for her use a	108 p.m. the director of nursing ral assessment completed 142 had no natural teeth and res. The DON stated the care was wearing dentures. The d not have any dentures at the and the care plan should have ect R42 no longer wore her				
	indicated, "The ca	cy with a review date of 1/16, are plan must be reviewed and as necessary, but at least every				
	R68's care plan, pri	int date 4/1/16, identified				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY	T GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 15	2 570			
	interventions of: da cares under abdom and Aveeno lotion of daily). On 3/28/16, at 4:43 R68 had two dark pright hand/wrist are	on in skin integrity, ecreased mobility with ily check for redness with a.m. inal fold and buttocks crease on back and arms BID (twice p.m., observation revealed burple bruises on top of R68's a. 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.					
	(NA)-H verified R68 hand/wrist area. R6 bruising was from h facility system was	6 a.m., nursing assistant B had bruising on his right B stated at the time the his watch. NA-H stated the the NA's usually report to the bruising is noted, then the es a report.				
	(RN)-D verified R68 his right hand/wrist not aware of the brusually identified br bath days or the NAThen a risk assess size of the bruise w bruising would be not the significant of the bruise with	6 a.m., registered nurse 3 had two bruises located on area. RN-D stated we were uising. RN-D stated the nurse ruising during body audits on As would report the bruising. ment would be completed, the rould be documented and the nonitored until healed. 1 a.m., NA-I stated we assist				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER	FM - I AKE CITY 500 WES	DRESS, CITY, S F GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	a.m. NA-I stated, w skin concerns or br skin, I put lotion on did not notice any s has those bruises. On 4/1/16, at 10:40 stated she would expond the care plan as had bruising before. The facility Care Plaindicated V. [five] concess are, but not related to preventive requiring care. VII. Individualized care resident. H. List present the Plan C. The resumble and revised (update Resident Care Planthe Plan C. The resumble and assign care for care plan must be and assign care plan must be and	68 with getting dressed this hen queried if R68 had any uising, R68 had very fragile R68's arms and shoulders, I kin concerns and R68 always a.m., the director of nursing spect bruising to be identified a problem area, as R68 has an Policy, review date 1/16, oncerns and problems B. It limited to: 8. Problems e care. 11. All problems [seven] Approach/Plan C. for the unique needs of the eventive measures. IX. [nine] e care plan must be reviewed ed) as necessary. XII. [12] a Documentation and Use of ident care plan is used to plan all disciplines. E. The resident expt current at all times. F. is to communicate all care plan esident care staff. of correction: The director of e) could review and make any to care planning policies and on revision of care plans. The udit care plans for accuracy essary. The facility then could go system as part of their	2 570			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMI			SURVEY PLETED
		00770	B. WING		04/0	01/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY	GRANT ST Y, MN 5504			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
2 830		MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General				5/3/16
	receive nursing car custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from to resident must remain in the state of the s	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed. ent is not met as evidenced on, interview and document ailed to ensure 1 of 1 resident ad dialysis services, had initial dialysis care, failed to ensure a dialysis cares and failed to		Corrected		
	coordinate care with addition the facility related skin concer reviewed for skin; from the comprehens residents (R86) reviservices; failed to id 1 of 4 residents (R6 ensure documentation a change of skin con (R61) reviewed for	In the dialysis center; in failed to identify non-pressure ins for 1 of 4 residents (R86) failed to identify missing teeth ive oral assessment for 1 of 3 iewed for dental status and dentify and monitor bruising for 58) reviewed for skin; failed to ion of physician notification for indition for 1 of 4 residents skin condition; failed to follow to obtain a lab value for 1 of 1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00770	B. WING		04/0	1/2016
_	PROVIDER OR SUPPLIER	M. I AKE CITY 500 WEST	DRESS, CITY, S F GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Although R125 was and had received the admission to the face coordination of care center and facility to dialysis as follows: R125 was admitted chronic kidney diseadmission record. R125's admission pridentified R125 was renal diet and fistulated and Saturdays and revealed the dialysi located in the front observations at this uncovered, clean at Document review of 3/24/16, revealed of on left antecubital (make sure bruit is highly the side of the sure bruit is highly the sure was sessment/interimental and saturdays and revealed in the front observations at this uncovered, clean at Document review of all the sure bruit is highly the sure	CARE PLAN TO ADDRESS DIALYSIS In new to dialysis treatments aree treatments since cility, there was no expended with the dialysis of ensure R125 tolerated on 3/23/16, with diagnosis of ase according to facility orogress note 3/23/16, alert and oriented, received a con left arm. 3/30/16, at 11:35 a.m., R125 ysis on Tuesdays, Thursdays, had no fluid restriction. R125 access sight was a fistula of the left upper arm. During time the fistula site was	2 830			
	care interventions s	cked evidence of any dialysis such as: risk factors, potential or specific dialysis related care				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	needs, special nutr risks for adverse m access site, infection measures, monitorion other monitoring reand after dialysis tragiving medications removing medications removing medications removing medications removing medications removing interview on registered nurse (Preceived fluid restragistered nurse (Preceived fluid restragistered nurse (Preceived fluid restragistered nurse). Buring interview on nursing assistant (Nall. NA-A stated naccess site, and if he call nurse. NA-A stated naccess site, and if he call nurse. NA-A stated not aware of know if fluids were. During interview on looked at R125's tragistered not aware of know if fluids were. During interview on looked at R125's tragistered nor nurse to monitor making sure the brastethoscope and the day and evening shindicated licensed palready completed morning. During in	itional and fluid volume needs, edication effects, care of the on control measures, skin careing of vital signs, weights and quirements, such as before eatments, instructions for (to prevent dialysis treatments on from the resident's system), etween the facility and dialysis address the "Do Not and advance directives. 3/30/16, at 11:41 a.m., and advance directives. 3/30/16, at 11:41 a.m., and if bleeding at fistula site, re and call charge nurse. 3/30/16, at 11:50 a.m., and call charge nurse.	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER	FM - LAKE CITY 500 WEST	DRESS, CITY, S F GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	monitored the bruit observe the bruit ar LPN-A stated they of for bruit and thrill. It another nurse and ID uring interview on verified was assign NA-B stated not awaccess sight and direstriction. During interview on stated the nurse who cares for the day not and communicated nursing assistants of dialysis. RN-B state assistants to provid assistant kardex in that time, RN-B ver R125 voided 1-2 time in left arm, and daily nursing assistant kardex in the dialysis port site diet, fluids, and embleeding at dialysis the nurse. RN-B st visits since admissis communication rep RN-B stated R125 or RN-B stated medical ordered and not away were to be held price verified R125's pread/interim care pland	and thrill. When asked to ad thrill check, RN-A and did not know how to monitor LPN-A stated would get left the floor. 3/30/16, at 1:18 p.m.,NA-B led to R125's hallway that day are of location of dialysis d not know if received fluid 3/30/16, at 1:20 p.m., RN-B led to check the calendar dialysis appointments to who care for R125 on days of led expected nursing le care according to nursing facility computer system. At lifted the kardex identified les a day, no blood pressure ly weight. RN-B verified the lardex lacked identification of les, care of dialysis resident, legency care. RN-B stated, if port sight, staff knew to get lated R125 had three dialysis on and verified no lorts received from dialysis. It was not on fluid restriction. Lations were administered as lated 3/23/16, indicated insufficiency, and no	2 830			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE			
MAYO C	LINIC HEALTH SYSTE	-M - I AK F (311 Y	T GRANT ST Y, MN 5504				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 21	2 830				
	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.						
		of facility Care of Dialysis iew date of 1/2016, revealed					
	after dialysis will on record will be used treatment and given staff after treatmen communication rec addressed comprel	ent communication before and cur. A dialysis treatment by the dialysis provider during n to the skilled nursing facility t as a summary and ord. Although the policy hensive care plan for dialysis not address initial dialysis					
		AND MONITORING OF NON TED SKIN CONCERNS:					
	have a bruises on t hands and right and documentation of the	on 3/28/16, at 4:49 p.m. to he top of his right and left d left forearms with no nese being found until the staff lem by this surveyor on					
		cian orders included ive 5 mg (milligrams) by ng for joint pain.					
	3/21/16, 3/14/16 an	ath forms dated 3/28/16, and 3/7/16 did not identify any of R86's hands or forearms.					
	"New Bruise or Foll	e dated 3/31/16 indicated, ow up: Bruising found on n measuring 2 x 1.2 cm					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER	M. I AKE CITY 500 WEST	ORESS, CITY, S GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	[centimeters], 1 x 1 also found on right 3 x 1.5 cm. Informato light purple in col R86's progress note "New Bruise or Foll left hand 1 x 1 cm [cm, right hand 14 x R86's plan of care of to, "monitor my skir bath." On 3/31/2016, at 10 (NA)-C stated resid bruises on their bat assessment was coalso stated if we se bruising during daily them up in the more stated she was unated this time. On 03/31/2016, at 10 nursing stated there medical record regarms or hands. The staff to document at The DON stated on assessment was con DON stated nursing at skin during morn notify the nurse of a residents' skin should applicate the staff to document and the staff to document	2.5 cm 3 x 2.4 cm, bruising elbow 19 x 2 cm, 4 x 8 cm and tion on Bruise: Bruising purple or, resident denies any pain." 2. dated 3/31/16 indicated, ow up: Bruises also found on centimeters], 8 x 7 cm, 3 x 2 8 cm." 2. dated 10/1014 instructed staff in with cares and with weekly 2.25 a.m. nursing assistant ents' skin was monitored for h days when a complete skin ompleted by a nurse. NA-C e any new concerns with y cares, when we are washing hing, we alert the nurse. NA-C ware of any bruising on R86 2. 2.51 p.m. the director of e was no documentation in the arding the bruising on R86's e DON stated she expected and monitor bruises for healing. bath days a full skin ompleted by the nurse. The gassistants should be looking ing and evening cares and any bruising. The DON stated and be looked on a daily basis. Substitute for monitoring non in conditions was requested	2 830			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	GRANT ST Y, MN 5504			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 23	2 830			
	ASSESSMENT AN INTERVENTIONS	EHENSIVE DENTAL D DEVELOPMENT OF BASED ON THIS MEET THE NEEDS OF THE				
	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.					
		rised 12/9/15, did not identify eth or any dental concerns.				
	nursing (DON) stated dental assessment did normissing teeth for condition DON stated she exteeth in the oral assecuted indicate miss section of the assection of the assection decked R86's oral completed by the far assessments address and the DON stated the plan for R86 that acceptance of the DON stated the plan for R86 that acceptance assessments addresses and the plan for R86 that acceptance assessments acceptance or the plan for R86 that acceptance assessments acceptance or the plan for R86 that acceptance assessments acceptance or the plan for R86 that acceptance assessment assessment as acceptance or the plan for R86 that acceptance are acceptance or the plan for R86 that acceptance are acceptance or the plan for R86 that acceptance are acceptance or the plan for R86 that acceptance are acceptance or the plan for R86 that acceptance are acceptance or the plan for R86 that acceptance are acceptance or the plan for R86 that acceptance or the plan for	t have an option to pick ondition of natural teeth. The pected staff to include missing sessment and stated staff ing teeth under the comments assessment. The DON stated she assessments that had been acility and stated none of the essed R86's missing teeth. Here was nothing in the care addressed missing teeth and and teeth should have been				
	instructed staff, "Ar be done on admiss with a significant ch	icy with a review date of 1/16, noral health assessment will ion, annually, quarterly and nange in resident's condition by (RN)Procedure:condition				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 24	2 830			
	of natural and artific	cial teeth"				
	LACK OF IDENTIF OF BRUISING:	ICATION AND MONITORING				
		on 3/28/16, at 4:43 p.m., to le bruises on top of his right a.				
	R68's quarterly Min identified diagnosis	imum Data Set dated 2/17/16, of anemia.				
		es identified R68 had prior forearm on 6/28/16, and the 15.				
	a problem area rela	s reviewed and did not include ted to R68's risk for bruising, vent bruising, nor interventions sing was identified.				
	(NA)-H verified R68 hand and wrist area system was the NA	6 a.m., nursing assistant 8 had bruising on his right a. NA-H stated the facility s usually report to the charge g is noted, then the charge ort.				
	(RN)-D verified R68 his right hand and were not aware of to nurse usually identification audits on bath days bruising. Then a riscompleted, the size documented and thountil healed.	6 a.m., registered nurse B had two bruises located on vrist area. RN-D stated we he bruising. RN-D stated the fied bruising during body or the NAs would report the k assessment would be of the bruise would be e bruising would be monitored 1 a.m., NA-I stated she had				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MAYO C	LINIC HEALTH SYSTE	-M - I AKE CITY	GRANT ST Y, MN 5504			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 25	2 830			
	stated, when querie concerns or bruisin put lotion on R68's	getting dressed this a.m. NA-I ed if R68 had any skin g, R68 had very fragile skin, I arms and shoulders, I did not cerns and R68 always has				
	facility system was the NA notifies the measures the bruis into risk management after discovery we winto place and try to occurred. The DON bruising to be report	a.m., the DON stated the anytime a NA sees a bruise nurse. The nurse then the and enters the information tent. Then around 24 hours work on an intervention to put to find out how the bruise of the stated she would expect the steed and would expect bruising the care plan as a problem and bruising before.				
	A policy for non-pre requested, but not p	essure skin conditions was provided.				
	RN-D to have an ar	on 3/30/16, at 1:27 p.m., with rea at the end of R61's right dried, hard and dark brown in				
		imum Data Set dated diagnosis of diabetes.				
	R61 was at risk for of pressure ulcers a anticoagulant medi	cation use, venous llar disease, incontinence,				
	3/18/16, incident: s	es identified the following: taff found what appears to be on resident's right great toe.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
MAYO C	LINIC HEALTH SYSTI	-M - I AK F CILY	T GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Area does not apper does not wear shown covered with blanker pinched when push meal time. Resider happened. Area me by 1.8 cm. Interven Physician notification R61's record failed the fax prepared. 3/20/16, follow up in resident sustained from his feet hitting wear shoes. He is a happened. Blister as scabbed over. Area No drainage or blee Dx (diagnosis) that type two diabetes. It contributed include novolog insulin. 3/20/16, blister is dyellow dry skin on to 3/24/16, blister righ blood under skin. 3/25/16, document cm x 1.2 cm area whard callous center area. R61's physician prointerview with the Didentified extremity R61's record failed notification of R61's change in condition included a diagnosi.	ear to be pressure as resident es and does not sleep with feet ets. His toe may have been sing his chair up to the table at it is unaware of what easures 1.7 cm (centimeters) tions: Apply alkare daily. on: fax prepared. However, to include documentation of incident, type of incident: blood blister injury possibly the dinner table. He does not unable to state what area now appears hard and a around toe appears healthy. eding. Will continue to monitor, may have contributed include Rx (medication) that may have metoprolol (beta blocker) and ark red/purple in color. Has	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	pressure area or no know if the area was had completed the not measured it. Rithe treatment would administration recofor the nurse to ma would appear in Right appear in Right and an area of the helister located of the blister loc	ot. RN-D stated she did not as measured weekly and she treatment yesterday and had N-D stated documentation for dibe on the treatment rd (TAR) and the TAR allowed ke a progress note, which then a progress notes. p.m., the DON verified R61's mentation of R61's physician e change in skin condition of an R61's right great toe. Thange in Condition review date 1/16, indicated g provider or provider on call esident's change in tus. Procedure: 1. Between as or typical wakeful hours, attending provider or provider ied of all conditions or health After hours, the attending on call should be notified of lition, health status or incident examples only): Resulted in a potential for provider locument time of call, provider locument time of call, provider locument time of call and	2 830			

6899

NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING	
MAYO CLINIC HEALTH SYSTEM - LAKE CITY 500 WEST GRANT STREET LAKE CITY, MN 55041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	/2016
LAKE CITY, MN 55041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
	(X5) COMPLETE DATE
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 Ifuid 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], BMF [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 3/3/1/6, idn 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 3/3/16, indicated that the BNP had not been done. When interviewed on 3/3/1/6 at 10:34 a.m.,	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	T GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	registered nurse (R not been done on 3 that the lab had not RN-I checked the chospital and confirm system. When interviewed chealth unit coordina BNP had not been HUC-D stated that lab, the HUC would system; once this withe order and confirm stated that it had not When interviewed codirector of nursing of should have followed ordered the lab test Review of the facilit Laboratory Orders The lab values to be provider orders. It could review and order A one-time order with under "other." A HL slip when the lab with notify the lab or the phone. Suggested method The administrator as could review and re to ensure residents services. The direct	N)-I stated that the BNP had 1/9/16 as ordered. RN-I stated the been done at all since 3/4/16. The been done in the been done at the physician ordered at the place it in the computer was done a nurse would check that it was in place. HUC-D at been done in this case. The following been done in this case. The following been done in the staff of the physician's orders and at	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	(2) MULTIPLE CONSTRUCTION (X3) DATE COMF		SURVEY PLETED
		00770	B. WING		04/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER		ORESS, CITY, S GRANT ST	STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTE	-M - I AKE CITY	Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 30	2 830			
	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.					
	time of Correction:	Twenty one (21) days.				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			5/3/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility f infection control pra perineal cares for 1 for urinary catheter and analysis of infe to affect all residen addition, the facility	ent is not met as evidenced ion, interview, and document ailed to ensure proper actices for catheter and of 3 residents (R68) reviewed; failed to ensure surveillance actions. This had the potential its, staff, and visitors. In failed to properly administer residents (R7) who received in.		Corrected		
	Findings include:					
	CATHETER AND P	PERINEAL CARES:				
	(NA)-G washed had changed a catheter leg bag for R68. NA	a.m., nursing assistant ands, donned gloves and drainage bag to a catheter A-G then with the same soiled R68's stockings, secured R68's				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG:	. COM	MPLETED
		00770	B. WING		04	/01/2016
		00770			04	/01/2010
NAME OF I	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CIT	Y, STATE, ZIP CODE		
		500	WEST GRANT	STREET		
MAYOC	LINIC HEALTH SYSTE	EM - LAKE CITY LAK	E CITY, MN 55	5041		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	N OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX		ACTION SHOULD BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		TO THE APPROPRIATE	DATE
				DEFIC	IENCY)	
21375	Continued From pa	nge 31	21375			
	•					
		R68's left thigh with a strap				
		om door, drained the urine				
		rainage bag into the toilet,				
		door to ask a staff person	for a			
		iner (to be used to clean				
		nage bag) and removed				
		y following this observation	n			
		ning hands placed R68's				
		pag inside of a garbage ca				
		oom. NA-G then placed th	ne			
		d removed on top of the				
		n was laid in the garbage o				
	NA-G then applied	R68's shoes and walked I	₹68			
		NA-G then donned clean				
		68's incontinent product, v				
		owel movement on the pa				
		oiled incontinent product o				
		ag laid in the garbage can				
		soiled gloves grabbed a v				
		room from a cupboard, pla				
		athroom sink, opened R68				
		d a clean incontinent produ	uct			
		vith putting on the clean				
		. NA-G then with the same				
		R68's clothes, assisted R	68 to			
		s and handed R68 a				
		his face. NA-G then with t				
		on cleansed around R68'				
		te and laid the washrag us				
		neal catheter site on top of				
		nage bag laid in the garba				
		h the same soiled gloves (
		bottle of normal saline and				
		iner and placed them bac				
		emoved the soiled gloves,				
	placed the dirty glo	ves and used				
		nto the garbage can on top	pf			
	R68's catheter drai	nage bag. NA-G then ope	ened			
		alked out of R68's room i				

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the hallway and obtained a clean a clean wash

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTE	FM - LAKE CITY 500 WEST	DRESS, CITY, S GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	cloth and towel from walked back into Re with hand sanitizer. and wash hands affincontinent product cares. NA-G continued to was observed to do to stand and washe cloth. NA-G then wipulled up R68' pant back to bedside and NA-G then removed wash basin, dried the towel and disposed garbage can on top bag. NA-G failed to hands after cleansin without washing har obtained R68's toot proceeded to brush with the same glove incontinent product the garbage, and pl plastic bags. NA-G removed R68's cath garbage can and producing and washed hands and wash hands afticatheter bag and factean catheter drain clean catheter drain clean catheter drain catheter drain clean catheter drain catheter drain catheter drain catheter drain clean catheter drain catheter dr	ge 32 In the linen cart. NA-G then 68's room and washed hands NA-G failed to remove gloves the removing a soiled and after providing perineal provide R68 with cares and the clean gloves, assisted R68 to R68's buttocks with a wash the same soiled gloves on a and assisted R68 to walk dist down on R68's bed. It dist down on R68's catheter drainage remove gloves and washing R68's buttocks. NA-G then reson removed R68's soiled and soiled wash cloth from acced the items in separate then with the same gloves on reter drainage bag from the roceed to rinse the catheter wo times using the clean er NA-G had filled with normal placed the catheter bag into a not the bag containing the 68's night stand drawer. NA-G resoned the privacy curtain NA-G filed to remove gloves and recent displaced to ensure R68's had a rege bag after having placed ge bag into a garbage can.	21375			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY 500 WES	DRESS, CITY, S F GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21375	On 3/31/16, at 7:52 about the observati R68 had just receiv that she had not rer hands to prevent in regarding if R68 har replied, "Yeah, he h Staphylococcus au R68's medication a 3/16, identified R68 (antibiotic) DS (dou (milligrams) one tak infection for 10 day 3/26/16, identified r times daily for 10 day a day 3/26/16, identified r times daily for 10 day a day 3/26/16, identified r times daily for 10 day 3/26/16, identified r times daily for 10 day a day	a.m., NA-G was interviewed ons made during the cares red from NA-G. NA-G agreed moved soiled gloves or wash fection. NA-G, when queried d any current infections ras MRSA [Methicillin-resistant reus] in his urine." dministration record, dated was receiving Bactrim ble strength) 800-160 mg blet two times a day for s. R68's progress note, dated new order: Bactrim DS one two rays and the reason was for on, MRSA. p.m., registered nurse (RN)-C reing treated with an antibiotic removed and hands washed eter bags, after cleansing I catheter site and after RN-C stated she would want to replace the catheter bag				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00770	B. WING		04/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - I AK F CILY	T GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 34	21375			
	catheter. 12. Store in bedside stand when the stand with the stand	drainage bag or leg bag to leg/drainage bag in Ziploc bag nen not in use after rinsing with emove gloves and wash				
	1/16, indicated prod area with soap and	oley Catheter Care, dated cedure: 7. Cleanse perineal water. 10. Dry perineal area. r to thigh with catheter strap. d wash hands.				
	indicated proper ha prevent spread of c employee and the r Washing is done: b	land Washing, dated 3/16, and washing is the best way to disease. It protects both the resident. Procedure: 1. Hand a. After handling contaminated gs, soiled linen, etc. g. after				
	LACK OF A FUNCT PROGRAM WHICH SURVEILLANCE A					
	Control Reports we through 2/2016. Th infections were indi 4/15, seven urinary respiratory, two skir 5/15, four UTI's, five 6/15, five UTI's, through 7/15, four UTI's, six other 9/15, eight UTI's, throne other	e respiratory, two skin ee respiratory, three skin ree respiratory, one skin respiratory, two skin, one nree respiratory, three skin,				
	one other 10/15, five UTI's, tw	vo respiratory, three skin				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00770	B. WING		04/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	M . I AKE CITY	F GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 35	21375			
		ne respiratory r respiratory, one skin respiratory, two skin				
	analysis of the infor	document surveillance and mation and infection control prevent the spread of the				
	documentation of s above information. hand hygiene and p nurses and nursing	p.m., RN-C stated she had no urveillance and analysis of the RN-C stated we talk about peri-cares during stand up, assistant meetings and unursing assistants providing				
	Control Program, un Infection Prevention with overseeing the This committee is reand facility wide Que The IPC carries the prevention, control within the facility. The oversight, review are infection control procompliance to qualistandards. III. Infect facility shall designate process of the infect IP responsibilities in surveillance of data reporting processes infection control surdata collection on neacility, as means for The surveillance data	fection Prevention and indated, indicated I. The in Committee (IPC) is charged infection prevention program. esponsible to the corporate ality Assurance Committee. It responsibility of surveillance, and reporting of infection in the IPC provides program in the provides guidance of the orgam, ensuring the facility's try infection prevention tion Preventionist (IP), each atte an RN, to coordinate the etion prevention program. The include: 9. Managing (gathering, analysis and is). IV. Surveillance, The recillance is the process of osocomial infection within the or early detection of outbreaks. It is additionally used to plan deducational programs. A.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	-M - LAKE CITY	T GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 36	21375			
	The process 2. Recreporting of the cas quarterly and annual Educational and cothis data.	cording, review, analysis and see data is done monthly, ally to detect trends. ntrol efforts are assisted by				
	TO PREVENT INFI					
		ord, dated 2/26/04, indicated diagnosis of a cataract.				
	resident received a both eyes two times. The physician orde that R7 received lul	ers, dated 7/1/05, indicated the rtificial tear solution: 2 drops in a day related to dry eyes. rs, dated 2/17/16, indicated oricant eye ointment: 1 ribbon in both eyes at bedtime related				
	nurse (RN)-F prepared RN-F knocked on F explained the process pair of gloves and expective eye drops. The lower eyelid of the touched the tip of the sclera (the white and administered oright eye. RN-F repleft eye. RN-F did to as well. RN-F then lubricant eye ointmethe procedure to R lowered the lower eadministered a ribb	ion of a medication /28/16 at 6:37 p.m., registered ared the medications for R7. R7's door, entered and edure to R7. RN-F put on a explained that R7 was to RN-F took the bottle of with one gloved hand, lowered the right eye. RN-F then he bottle of artificial tears to be outer layer] of the eyeball ne drop of artificial tears to the eated this process with R7's buch the sclera of R7's left eye prepared to administer ent from a tube and explained 7. With a gloved finger, RN-F eyelid of R7's right eye and on of ointment underneath the again touched the tip of the				

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STATE FORM 6899 VG2D11 If continuation sheet 37 of 50

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			P WING			
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTI	EM - LAKE CITY	T GRANT ST 'Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	tube where the mer repeated this proces process, the tip of touched underneat. When interviewed a stated that he migh lower lid of the left eye lubricant. When interviewed a stated when admin nurse should never of the container. Riwere to have an infone eye, the infectito the other. When interviewed a director of nursing who administered the eye lubricant should with the tip of the management and the eye or anything else suggested infection control correview infection control correview infections. The facilimplement an audit implement an audit infections. The facilimplement an audit infections.	dication was applied. RN-Fess to the left eye. In the che tube of eye lubricant again the tube of eye lubricant again the the lower left eyelid. On 3/28/16 at 6:42 p.m., RN-Fest have touched underneath the eye with the tip of the tube of on 3/30/16 at 11:00 a.m., RN-Jistering eye medications, the touch the eyeball with the tip N-J stated that if a resident fection (such as pinkeye) in on would spread from one eye on 4/1/16, at 12:43 p.m., the (DON) stated that the nurse he eye drops as well as the d not have touched the eye nedication containers. Imment titled, "Administering Eye it explained the proper nistering eye medications. It hing the dropper against the	21375	DELICITY STATES OF THE PROPERTY OF THE PROPERT		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MAYO CI	LINIC HEALTH SYSTE	-M - I AKE CITY	T GRANT ST Y, MN 5504				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 38	21375				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426			5/3/16	
	maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements	e provider must establish and mensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease ation (CDC), Division of mation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.					
	by: Based on interview facility failed to ens and 1 of 5 residents skin testing (TST) a Disease Control an guidelines; failed to (HUC- F) reviewed	ent is not met as evidenced and document review, the ure 1 of 5 employees (NA-L) s (R77) received a tuberculin according to the Centers for d Prevention (CDC) ensure 1 of 5 employees had TB education; failed to Tuberculosis (TB) infection		Corrected			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21426 Continued From page 39 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE DEFICIENCY)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
MAYO CLINIC HEALTH SYSTEM - LAKE CITY SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21426 Continued From page 39 21426			00770	B. WING		04/0	1/2016
(X4) ID PREFIX TAG COntinued From page 39 LAKE CITY, MN 55041 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21426	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21426 Continued From page 39 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) 21426	MAYO C	CLINIC HEALTH SYSTI	EM-IAKE CIIV				
	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
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 Hr 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	21426	control program incipaled to develop a that included proce isolation for handlin disease as required affect all residents, Findings include: LACK OF TWO ST THE CDC GUIDEL Nursing assistant (I record was reviewed hired on 12/21/15, 7/7/15, with reading 7/9/15. The first stedated within 90 day On 3/31/16, at 12:3 (RN)-C verified the LACK OR TB COM GUIDANCE FOR F R77 was admitted dated 1/22/16, indicated to a TB TS 1/16/16, indicated to a fall. The chest x-required. On 3/31/16, at 12:3 R77 and NA-L the rewas not completed LACK OF TB MAN	cluded all areas as required; written infection control plan edures for early recognition and ag persons with active TB d. This had the potential to staff and visitors. TEP TST ACCORDING TO INES FOR STAFF: NA)-L's employee personnel ed and identified NA-L was and had a first step TST on g of 0 mm (millimeters) on ep TST recorded failed to be as of hire as required. S p.m., registered nurse above. IPLIANCE PER CDC RESIDENTS: on 1/22/16. R77's TB screen cated R77 had an adverse ST. R77's chest x-ray dated the reason for the x-ray was for ray failed to address TB as S p.m., RN-C said for both requirement for CDC TB guide to DATED TRAINING PER CDC:	21426			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.			
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY	T GRANT ST 'Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	(DON) to not have stated HUC-F woul reason HUC-F had HUC-F attends sch HUC-F's hire date working on the flooresidents. TB INFECTION COTHE FOLLOWING Review of the facilit dated 2015, indicatinfection control TB one or more depen However the policy persons were on the facility and who the In addition, the policinfection control protection control protect	had TB education. The DON d attend in May 2016 and the not attended was due to nool. The DON verified was 1/23/16, and HUC-F was r and had contact with DNTROL PROGRAM LACKED: ty policy TB Control Plan, ed each facility shall: form a team. This can be a team of ding on size of the facility. failed to identify how many e infection control team for the persons were. cy failed to include written ocedures and failed to address ker education. cy TB Control Plan, dated resident develops symptoms e administered and resident is opriate facility, and notify MDH ment of Health] of possible ontrol plan failed to include control procedures for early lation for residents with active	21426	DEFICIENCY)		
	about working with	cy failed to include information the local or state public health duct a TB contact investigation				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COMPLETED	
		00770	B. WING		04/0	01/2016
	PROVIDER OR SUPPLIER	M. I AKE CITY 500 WES	DRESS, CITY, ST T GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	On 3/31/16, at 12:3 current policy lacke above. The facility policy Trindicated the facility Plan in compliance Control guidelines a Minnesota Occupat (OSHA) TB require SUGGESTED MET The director of nursipolicies and proced The director of nursiemployees regarding facility infection control.	ciated transmission of M. bected. 5 p.m., RN-C verified the d information in regards to B Control Plan, dated 2015, a shall develop a TB Control with current CDC TB Infection and consistent with the ional Health and Safety ments. CHOD OF CORRECTION: sing could review tuberculosis ures to ensure compliance. sing could educate alling TB education and the	21426			
21620	MN Rule 4658.1348 Drugs used in the n in accordance with	ursing home must be labeled	21620			5/3/16
	by: Based on observati review, the facility fa were labeled accord of 25 medications re	ent is not met as evidenced on, interview and document ailed to ensure medications ding to physician's orders for 3 eviewed during medication affected 3 of 8 residents (R7,		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER	EM - LAKE CITY 500 WEST	DRESS, CITY, S F GRANT ST TY, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21620	Findings include: R7 was observed dadministration on 3 nurse (RN)-F administration in eye ointment in each medication instructed daily to the right eye R7's admission recindicated that the recataract. R7's physician order that the resident was ointment 1 ribbon in When interviewed a stated that the labe was incorrect. RN-F procedure when an physician was to pusticker on the mediorder had changed staff to look at the a R72 was observed administration on 3 administered 0.5 m antianxiety medicat medication instruction four times a day an treatment.	uring a medication /28/16 at 6:37 p.m., registered nistered one ribbon of lubricant th eye of R7. The label on the ed staff to administer twice e only. ord, dated 2/26/20014, esident had a diagnosis of a ers, dated 2/17/16, instructed as to receive lubricant eye in each eye at bedtime. on 3/28/16 at 6:42 p.m., RN-FI on the lubricant eye ointment estated that the correct order had changed by the at a "change of directions" cation which indicated that the That would notify the nursing actual physician's order. during a medication /30/16 at 1:41 p.m., RN-J g (milligrams) of Ativan (an ion) to R72. The label on the ed to administer Ativan 0.5 mg d as needed 1/2 hour prior to	21620			
	indicated that the regeneralized anxiety					
		ders, dated 12/17/15, indicated as to receive Ativan 0.5 mg				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00770	B. WING		04/0	1/2016
	PROVIDER OR SUPPLIER LINIC HEALTH SYSTI	FM - LAKE CITY 500 WEST	DRESS, CITY, S F GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	four times a day. R72's medication a from 3/1/16 through resident had receive physician. When interviewed a licensed practical in label on R72's Ativated that the change of direction medication packet that the orders had when an order was also notified so when it would have the control of	dministration record, reviewed a 3/31/16, indicated that the ed Ativan as prescribed by the en 3/30/16 at 3:32 p.m., rurse (LPN)-D stated that the an medication was incorrect. There should have had a noticate to the nursing staff changed. LPN-D stated that changed, the pharmacy was en a new prescription was sent correct order written on it. Indicate to the nursing staff changed of the pharmacy was en a new prescription was sent correct order written on it. Indicate to the nursing staff changed of the pharmacy was en a new prescription was sent correct order written on it. Indicated that R107 was a twice a day and every 6 hours greater than 5 on a 0 to 10 the most excruciating. Indicated 10/15/15, ent had a diagnosis of a sthoracic vertebra. Inderest dated 10/20/15, esident had an order for administration record, 16 through 3/31/16, indicated decived Tylenol 1000 mg by	21620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00770	B. WIN	IG		04/0	1/2016
NAME OF PROVIDER OR		EM - LAKE CITY 500	EET ADDRESS, WEST GRAI E CITY, MN	NT ST			
PREFIX (EACH I	DEFICIENC'	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
incorrect. needed a in order to was differed medication "change of the director of should have on the mediffering of package." should be changed of the director of Medication was respondosage so administration the medicated a use of the question the nurse was clarification staff responding to the staff responding to the director of the director of the question the nurse was clarification staff responding to the director of the	the laber RN-H state and the laber RN-H state and the laber record indicate and for the policity of the polici	I on the Tylenol for R107 vited that the medication particle of direction" sticker affixed to the nursing staff the ord what was written on the e. RN-H then did place a n" sticker on the medication of A/1/16 at 12:45 p.m., the (DON) stated that the staff lection of direction sticker to indicate that there was the instructions on the lection of the lection order to get the instruction medication orders. I wittled, "Administering it instructed that the nurse of checking to see the drug on the resident's medication orders. If the medication or ders, the container. If the medication or there was any reason or there was any reason or there was any reason or the dosage interval, the order of Nursing could in-see or the dosage interval, the order of Nursing could in-see or medication administration administration administration administration administration according accurate dispension of the CORRECTION:	cket I to it I	20			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00770	B. WING		04/0	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTE	-M - I AKE CITY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 45	21665			
21665	MN Rule 4658.1400 Physical Environment		21665			5/3/16
	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.					
	by: Based on observati review, the facility follows were covered to	on, interview, and document ailed to ensure wheelchair with a cleanable surface for 1 whose wheelchair legs were in like substance.		Corrected		
	Findings include:					
	R31's wheelchair le like substance.	gs were covered with a foam				
		that included osteoporosis, niparesis, according to facility				
	staff pushed R31 in Observations at that	29/16, at 9:50 a.m., revealed a wheelchair to R31's room. It time revealed both re covered with foam like place with straps.				
	environmental serv covering wheelchai was porous and no stated physical the wheelchair legs be	3/31/16, at 10:30 a.m., ices director verified the foam r legs. He stated the surface t a cleanable surface. He rapy had requested the covered for resident safety.				
ı	During interview on	3/31/16, at 2:03 p.m.,				

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STATEMENT OF DEFICIENCIES (X1)

_	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		00770	B. WING		04/0	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MAYO CI	LINIC HEALTH SYSTE	-M-IAKE CHY	GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 46	21665			
	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.					
	The administrator a director could revier procedures to ensu cleanable surfaces. in-service all staff to	HOD OF CORRECTION: and environmental services w and revise policies and re use of padding with The director of nursing could be ensure cleanable surfaces ector of nursing could monitor				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21855	MN St. Statute 144 Residents of HC Fa	.651 Subd. 15 Patients & ac.Bill of Rights	21855			5/3/16
	residents shall have and privacy as it rel personal care progression, exami confidential and sha Privacy shall be residential, and other a	nent privacy. Patients and the the right to respectfulness ates to their medical and ram. Case discussion, nation, and treatment are all be conducted discreetly. Spected during toileting, activities of personal hygiene, or patient or resident safety or				
	by: Based on interview facility failed to pror and personal inform forms for 2 of 2 res	and document review, the mote confidentiality of medical nation for both oral and written idents (R73 and R51) entiality and privacy.		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
MAYO C	LINIC HEALTH SYSTE	M . I AKE CITY	T GRANT ST Y, MN 5504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21855	Continued From pa	ge 47	21855			
	3/29/16 at 12:42 p.r staff speak privately about your relative's behavioral condition they speak to me al be. So if I happen to in the hall and it is r. On 03/31/2016 at 1 nursing (DON) state communicate with f DON stated speaking hallway about a resconcerns would not confirmed the facilit discuss patient info	:57 p.m., the director of ed she expected staff to amilies in a private area. The ng to a family member in the ident's medical or behavioral be private. The DON ty policy instructed staff to not rmation in a public area. Policy with a review date of atient information will not be				
	R51's medical infor anyone in the count 7:11 a.m. A comput hallway wall was op walked down the ha able to view the info screen identified the for R51: R51's first weekly tub bath, bo cream [skin protect Teds [compression calmoseptine [topic and peri-area with cevery two hours, events in the county street in the county stre	mation was in full view of try view hall on 03/31/16, at er screen mounted on the pen, and any person that allway pass the screen was ormation on the screen. The er following health information and last name, room number, wel movements, laniseptic ant] to sacrum every shift, stockings] on in a.m., al ointment] to upper thighs cares, turn and reposition ery shift bed mobility, check bdominal folds, under breasts,				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00770	B. WING		04/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	M - I AKE CITY	「GRANT ST Y, MN 5504			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21855	Continued From pa	ge 48	21855			
	cares to check redr folds, and buttocks in bed at all times a mouth every a.m.	lly during care, daily with a.m. ness under breasts, abdominal crease, grippy socks on when nd Vaseline to corners of				
	walked by the screenurse (RN)-E, a conassistant (NA)-G wa.m., a construction At 7:17 a.m., NA-G a.m., nursing assist screen. At 7:20 a.m. walked by the screethree construction in the a.m., one resident wheelchair in front resident walked by a walker. At no time resident's informatic unauthorized visual					
	screen was open at was on the screen.	a.m., NA-G verified the nd R51's health information NA-G stated sometimes the see and NA-G then closed the				
		p.m., the DON stated she creen to be closed out when screen.				
	[Health Insurance F Act] passed in 1996 health information,	information of the HIPPA Portability and Accountability 5, which indicated protected anything that identifies the r monitors are not exposed to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00770	B. WING		04/0	1/2016
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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETE DATE DATE	
21855	Continued From page 49		21855			
	nursing (or designe policies and proced necessary changes training program, at members. The facil implement an audit quality assurance p compliance.	of correction: The director of e) could review their HIPPA lures, review and make any to privacy and confidentiality nd provide education to staff ity could then develop and ing system that is part of their rogram to maintain ection: Twenty one (21) days.				

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