Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 4, 2025

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: July 31, 2025

Dear Administrator:

On July 31, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 20, 2025

Administrator
Mayo Clinic Health System - Lake City
500 WEST GRANT STREET
LAKE CITY, MN 55041

RE: CCN:245218
Cycle Start Date: July 31, 2025

Dear Administrator:

On July 31, 2025, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 October 31, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by January 31, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayo Clinic Health System - Lake City	500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 7/28/25-7/31/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		08/21/2025
F0000	INITIAL COMMENTS On 7/28/25-7/31/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52181076C (MN 00112360, iQIES 1166309), H52181078C (MN 00109047, iQIES 1166288), H52181079C (MN 00109045, iQIES 1166290),H52181077C (MN 00110022, iQIES 1166296) . NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		08/21/2025
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations	09/08/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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F0880 SS = D	Continued from page 1 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will	F0880	Continued from page 1 stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. Corrective Action: Daily infection control rounds were initiated to ensure compliance with EBP practices for resident (R5). Corrective Action as it applies to other residents: The Enhanced Barrier Precautions policy was reviewed and remains current. Staff will be re-educated regarding the Enhanced Barrier Precautions policy to ensure proper PPE is being utilized. Re-education includes proper donning and doffing of PPE, identifying residents requiring EBPs, and understanding rationale for EBPs. The Disinfecting of Reusable Equipment and Environmental Surfaces policy was reviewed and remains current. Staff will be re-educated regarding this policy to ensure equipment is being disinfected between uses. Equipment was reviewed to ensure that each item has the appropriate disinfecting wipes. Reviewed residents who require Enhanced Barrier Precautions to ensure proper signage and supplies outside of each room. Changes made as necessary. Reoccurrence will be prevented by: Audits of Enhanced Barrier Precautions and cleaning of equipment will be conducted three times a week for two months to ensure proper infection control procedures. Results of the audits will be reviewed at QAPI for follow-up and recommendations to ensure ongoing compliance and those solutions are sustained. The Correction will be monitored by: Director of Nursing or designee. Date of Completion: 9/8/2025	

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F0880 SS = D	Continued from page 2 transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP) were implemented with the use of personal protective equipment (PPE) during high-contact resident care activities for 1 of 1 residents (R5) who had a foley catheter, and failed to ensure shared resident equipment was disinfected between uses. Findings include: R5's annual Minimum Data Set (MDS) assessment dated 6/4/25, identified intact cognition, and substantial/maximal assist was required for bathing and dressing. R5 had an indwelling catheter and diagnoses of severe obesity, heart failure and renal insufficiency. R5's Incontinence/Indwelling Catheter Care Area Assessment (CAA) dated 6/12/25, was triggered due to assistance needed with toileting and an indwelling catheter was required. R5's care plan dated 2/10/25, identified EBP indefinitely due to foley catheter use. Required PPE included gloves and gown prior to the high-contact care activity; Face protection may also be needed if performing activity with risk of splash or spray. High-contact resident care activities such as but not limited to:	F0880		

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F0880 SS = D	Continued from page 3 * Dressing * Bathing/showering * Transferring * Providing hygiene * Changing linens * Changing briefs or assisting with toileting * Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator * Wound care: any skin opening requiring a dressing. Examples of activities not requiring use of Enhanced Barrier Precautions: A. During interviews B. Hygienic medication administration C. Meal tray delivery D. Not physically coming in contact with patient During an observation and interview on 7/28/24 at 6:24 p.m., R5's room entrance had EBP signage directing staff to wear gown and gloves for bathing and high contact care. In the room, NA-A had a basin of soapy water and a washcloth and provided R5 with a bed bath. NA-A had gloves on, lacked a gown on while providing the bed bath. NA-A washed R5's torso, leaning over the bed with scrubs touching R5's bed. When asked about PPE, NA-A stated there was a central bin of PPE in the hallway, however, PPE was only required for care of R5's catheter. R5 then stated staff only wear gowns when they take care of his catheter. During an interview on 7/28/25 at 6:34 p.m., registered nurse (RN)-A stated EBP PPE was only required during the care of R5's device. R5's EBP signage was reviewed with RN-A, who then stated NA-A should probably have a gown on while providing the bed bath and not just for catheter care. During an interview with the infection preventionist (IP) and director of nursing (DON) together on 7/30/25 at 2:33 p.m., the infection preventionist stated shared equipment cleaning and EBP skills were reviewed at orientation and ongoing training. After leaving a	F0880		

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F0880 SS = D	Continued from page 4 resident room with shared equipment, the equipment should be cleaned and disinfected with the appropriate wipes. The purpose of EBP and disinfecting shared equipment was to prevent spread of multidrug-resistant organisms (MDROs) to residents and staff. The facility's EBP policy dated 1/22/25, identified MDRO EBP expands the use of PPE beyond situations in which exposure to blood and body fluids was anticipated, and referred to the use of gown and gloves during high-contact resident care activities which provide opportunities for transfer of MDROs to staff hands and clothing. EBP were indicated for residents with any of the following: infection or colonization with a MDRO when contact precautions do not otherwise apply; or wounds and or/indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. During observation on 7/29/2025 at 2:16 p.m., nursing assistant (NA)-A and NA-B entered room 109 with a facility lift to assist resident. Upon exiting, NA-A immediately took garbage to soiled utility room. NA-B exited room without disinfecting lift, placed lift against opposite wall and went into soiled utility room. NA-A exited soiled utility room and entered room 107 to answer the call light. NA-B exited soiled utility room and entered room 107 to assist NA-A. RN-A grabbed the lift against the wall that had not been disinfected, RN-A took that lift into room 121 without disinfecting the lift. During interview on 7/29/2025 at 2:37 p.m., NA-A and NA-B stated the process for disinfecting lifts was to disinfect the lift in the hall immediately after you were done using it. NA-A and NA-B both confirmed neither of them had disinfected the lift before placing it against the wall. NA-A and NA-B stated the lift should have been disinfected immediately after use to prevent the spread of infection from one resident to another. During interview on 7/29/2025 at 2:43 p.m., registered nurse (RN)-A stated the process was to disinfect lifts immediately after every use. RN-A stated the lifts should be disinfected after every use to prevent the spread of infection. Per facility policy titled Disinfecting of Reusable Equipment and Environmental Surfaces dated 11/8/24, reusable equipment and environmental surfaces will be properly disinfected.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/29/2025. At the time of this survey, MAYO CLINIC HEALTH SYSTEM - LAKE CITY was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		08/21/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. MAYO CLINIC HEALTH SYSTEM - LAKE CITY is a one-story building having no basement. The building was constructed at 2 different times. The original building was built in 1977 and was determined to be of Type I (332) construction. In January 2003, the chapel addition was built and was determined to be of Type I (332) construction. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. A 2-hour fire separation exists between the nursing home and the clinic, and the hospital. The facility is fully protected throughout by an	K0000		

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K0000	Continued from page 2 automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K0920	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. Identified appliances are now connected directly to an outlet. Identified relocatable power taps were removed. Power taps will not be daisy chained. An audit of appliances and power taps will be conducted to ensure proper use. If any additional issues are noted, they will be fixed. Administrator or designee will re-educate staff on the proper use of appliances and power taps. Reoccurrence will be prevented by: Audits will be conducted weekly for 2 months and randomly thereafter for 3 months to ensure compliance. Results of the audits will be reviewed at QAPI for follow-up and recommendations to ensure ongoing compliance and those solutions are sustained. The Correction will be monitored by: Administrator or designee. Date of Completion: 9/8/2025	09/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayo Clinic Health System - Lake City	500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0920 SS = E Bldg. 01	Continued from page 3 1. On 07/29/2025 at 12:15 PM, it was revealed by observation that in the Chapel, an appliance was connected to a relocatable power tap. 2. On 07/29/2025 at 12:30 PM, it was revealed by observation that in the Office Area (LN 1-715) a relocatable power taps were found daisy chained. 3. On 07/29/2025 at 12:35 PM, it was revealed by observation that in the Office Area (LN 1-715) that appliance(s) were connected to a relocatable power tap. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0920		