

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 8, 2020

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

RE: CCN: 245218 Cycle Start Date: September 24, 2020

Dear Administrator:

On September 24, 2020, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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

Mayo Clinic Health System - Lake City October 8, 2020 Page 2

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" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

### 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 December 24, 2020 (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

Mayo Clinic Health System - Lake City October 8, 2020 Page 3 Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 24, 2021 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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

Feel free to contact me if you have questions.

Sincerely,

Mi Jaig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPAR	IMENT OF HEALTH	I AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	`´CON	E SURVEY IPLETED
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				l	LAKE CITY, MN 55041		
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		plaint was found to be 18029. Deficiencies issued at					
	The following comp unsubstantiated: H	laints were found 5218028C and H5218027C.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
E 600	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with	ГС	200			11/2/20
SS=D	Reporting of Allege CFR(s): 483.12(c)		F 6	509			11/2/20
		onse to allegations of abuse, n, or mistreatment, the facility					
	involving abuse, ne mistreatment, inclu	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property,					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						10/16/2020

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.

PRINTED: 10/23/2020

STATEMEN	F OF DEFICIENCIES	KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,	IPLE CONSTRU			E SURVEY PLETED	
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	that cause the alleg serious bodily injur the events that cau abuse and do not r the administrator o officials (including and adult protective provides for jurisdie	gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if ise the allegation do not involve result in serious bodily injury, to f the facility and to other to the State Survey Agency e services where state law ction in long-term care ance with State law through lures.						
	designated represe accordance with S Survey Agency, wit incident, and if the appropriate correct	ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced						
	Based on interview facility failed to imm staff-to-resident ve	v and document review the nediately report an allegation of rbal abuse to the state agency urs for 1 of 3 residents (R2) a		Complia deficien deficien not to b against	ssion of this Allegation ance is not a legal adr ncy exists or that this S ncies was correctly cite be construed as an adr the Facility, Administr rees, Agents or other i	nission that a Statement of ed and is also mission rator, of any		
	R2's initial vulneral the SA on 1/16/20 reported to DON [c nursing assistant [a to be yelling at resi nursing] spoke with appreciate her tone assist him with car	ble adult report submitted to included "2 staff members lirector of nursing] that a travel alleged perpetrator] was found dent [R2]. DON [director of n [R2] and he did not e. It appears she wanted to es and [R2] told her no. br] began to yell at [R2]		who dra Allegati prepara Allegati constitu of any k any fact conclus the surv	aft or may be discusse on of Compliance. In a ation and submission of on of Compliance doe ate an admission or an kind by the Facility of t ts alleged or the corre- sions set forth in the So vey agency. According has prepared and sub	ed in the addition, of the es not a agreement he truth of ctness of any tatement by gly, the		

Facility ID: 00770

If continuation sheet Page 2 of 6

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	because she became offended when [R2] talked back to her. DON [director of nursing] will be interviewing staff and residents to obtain a clearer picture of this staff member and whether or not the issue is widespread. DON [director of nursing] has reached out to [pool agency] and they are			Allegation of Compliance of the requirements und Federal law that mandat an Allegation of Complia days of receipt of the Sta Deficiencies as a conditi	er State and te submission of ance within ten atement of ion of participation	
	this report. DON [d day investigation w taken to keep [R2]	e staff member as I am typing irector of nursing] will submit 5 hen complete. Actions will be and other residents safe n." Review of the initial report		in Title 18 and Title 19 p submission of this Allega Compliance within this ti in no way be considered an agreement with alleg	ation of imeframe should l or construed as	
	1/16/20, at 5:00 a.m	realed the incident occurred on n. and the initial report was 1/16/20 at 9:55 a.m.		noncompliance or admis facility. This plan of corre construed as an admiss or any of its agents that	ssions by the ection is not to be ion by the facility	
	nursing assistant (I reported the incide			findings in this report are The plan of correction is purpose of compliance v participation for the Med	written for the with the rules of	
		on 9/24/20, at 4:44 p.m., urse (LPN)-A stated she did		Medicare programs.		
		now she notified the DON and have emailed or told him in		On 9/24/2020, MDH con complaint survey and no failed to immediately rep of staff to resident verba	oted the facility port an allegation	
	administrator stated to be submitted to s hours of being repo	o on 9/24/20, at 5:54 p.m., the d any alleged abused needed state agency (SA) within 2 orted. The administrator stated		state agency within two residents (R2) reviewed is correcting this tag thro interventions:	hours for 1 of 3 for abuse. Facility ough the following	
	after hours and the filing the report to the verified the initial re	e DON via phone if offsite or DON was responsible for he SA. The administrator port was filed over 4 hours is after the incident occurred.		Administrator will review procedures regarding re alleged abuse, neglect, Allegations of abuse, ne mistreatment will be rep	porting of all or mistreatment. glect, or	
	The administrator s report any allegatio	stated he would expect staff to n of abuse timely and would b be filed to the state agency		agency within two hours Administrator or designe staff on the two hour tim reporting allegations of a mistreatment. Staff will b	ee will re-educate eframe for abuse, neglect, or	

Facility ID: 00770

If continuation sheet Page 3 of 6

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If continuation sheet Page 4 of 6

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	of abuse for 1 of 3			ficiency exists or that this Sta			
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		to DON [director of nursing]			legation of Compliance. In add		
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		reciate her tone. It appears			any kind by the Facility of the		
		st him with cares and [R2] told			ny facts alleged or the correctr Anclusions set forth in the State		
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		[pool agency] and they are			Allegation of Compliance with		
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		hen complete. Actions will be			Title 18 and Title 19 programs		
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		nt occurred on 1/16/20, at 5:00			agreement with allegations o ncompliance or admissions b		
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		., indicated the resident (R2)			dings in this report are true or		
		vere interviewed. However,			ne plan of correction is written		
		mentation of these interviews			Irpose of compliance with the		
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		npleted related to the incident.			odiodro programa.		

Facility ID: 00770

If continuation sheet Page 5 of 6

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	Сом	E SURVEY PLETED
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F 610	During an interview DON stated he sum 5 day report and did of the interviews. D document other res the 5 day report. DO interviewed others I in the report and the the interviews, he d it up. DON verified reproducible. During an interview administrator stated verified the docume interviews cannot b administrator stated have right now" and documentation of th to be kept. The Vulnerable Add dated 4/19 included Manager or Directo will immediately ins of the reported alled investigation may in a. Interviews of st from staff involved b. Resident interview	on 9/24/20 at 2:12 p.m., the marized his interviews in the d not keep his documentation ON stated he would normally sidents or staff interviewed in ON stated he believed he but since it was not indicated ere was no documentation of loes not have anything to back his investigation was not on 9/24/20, at 5:54 p.m., the d he spoke to the DON and entation of investigation and e reproduced. The d, "It sure would be nice to d would expect all he investigation and interviews ult - Abuse Prohibition Plan d, The Building Charge, Nurse r of Nursing, or Administrator titute an internal investigation gation or incident. The helude but not limited to; aff and written statements in the incident	F 61	10 complaint survey and note failed to thoroughly investion of abuse for 1 of 3 resident reviewed. Facility is correct through the following interve Administrator will review p procedures around conduct and thorough investigation submitted to the state age supporting documentation and resident interviews. Administrator or designee leadership on the important completing and document the investigation, including resident interviews. Educat completed by 10/30/2020. Audits will be conducted w months and randomly ther months to ensure reports the agency contain the proper documentation. Results of be reviewed at the Quality Committee for follow up and recommendations to ensure compliance and those solut sustained. Administrator will be respondent ensure compliance.	gate allegations ts (R2) sting this tag ventions: olicies and cting a complete a. Reports ncy will contain , such as staff will re-educate nce of ing all parts of staff and tion will be veekly for two reafter for three to the state interviews and the audits will Assurance nd re ongoing utions are	

Facility ID: 00770

If continuation sheet Page 6 of 6



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 8, 2020

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

Re: State Nursing Home Licensing Orders Event ID: LHXY11

Dear Administrator:

The above facility was surveyed on September 24, 2020 through September 24, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 October 8, 2020 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 immediately contact:

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

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.

Mighing

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minneso	ota Department of He	alth				
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	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
1	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
1	conducted to detern Licensure. Your fac	rS: reviated survey was mine compliance with State sility was found to NOT be IN MN State Licensure.				
		laint was found to be H5218029 and licensing				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE iically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE 10/16/20

Electronically Signed

STATE FORM

If continuation sheet 1 of 4

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BUILDING.	·	с
		00770	B. WING		09/24/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
	LINIC HEALTH SYST	EM - LAKE CITY	ST GRANT ST TY, MN 5504		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
2 000	Continued From pa	ige 1	2 000		
	orders were issued				
	UNSUBSTANTIAT	plaints were found to be ED: H5218028C and censing orders were issued.			
	signature is not req page of state form. is required, it is req	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility pt of the electronic documents			
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995		11/2/20
	(a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an intern mandated reporter requirements of this internally. Howeve	I reporting of maltreatment. all establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains nplying with the immediate ents of this section.			
	by: Based on interview facility failed to imm staff-to-resident ver	ent is not met as evidenced and document review the nediately report an allegation o rbal abuse to the state agency irs for 1 of 3 residents (R2)		Submission of this Allegation of Compliance is not a legal admiss deficiency exists or that this State deficiencies was correctly cited a not to be construed as an admiss against the Facility, Administrator	ement of nd is also sion
	Findings include: R2's initial vulnerat	le adult report submitted to		Employees, Agents or other indiv who draft or may be discussed in Allegation of Compliance. In addi	iduals the
		ncluded "2 staff members		preparation and submission of the	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00770	B. WING		09/24	1/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYST	EM . LAKE CITY	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 APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21995	Continued From pa	ige 2	21995			
21993	reported to DON [d nursing assistant [a to be yelling at resid nursing] spoke with appreciate her tone assist him with care [Alleged perpetrato because she becar back to her. DON [d interviewing staff ar picture of this staff the issue is widespi has reached out to addressing with the this report. DON [di day investigation wit taken to keep [R2] during investigation made to the SA rev 1/16/20, at 5:00 a.n made to the SA rev 1/16/20, at 5:00 a.n made to the SA on During an interview nursing assistant (N reported the incider During an interview licensed practical n not recall when or h indicated she may h person. During an interview administrator stated to be submitted to s hours of being repo staff are to notify th after hours and the	irector of nursing] that a travel alleged perpetrator] was found dent [R2]. DON [director of [R2] and he did not b. It appears she wanted to es and [R2] told her no. r] began to yell at [R2] ne offended when [R2] talked director of nursing] will be nd residents to obtain a clearen member and whether or not read. DON [director of nursing] [pool agency] and they are e staff member as I am typing irector of nursing] will submit 5 hen complete. Actions will be and other residents safe n." Review of the initial report realed the incident occurred on n. and the initial report was 1/16/20 at 9:55 a.m.		Allegation of Compliance does not constitute an admission or an agre of any kind by the Facility of the tru any facts alleged or the correctness conclusions set forth in the Statem the survey agency. Accordingly, the Facility has prepared and submitted Allegation of Compliance solely be of the requirements under State a Federal law that mandate submiss an Allegation of Compliance within days of receipt of the Statement of Deficiencies as a condition of part in Title 18 and Title 19 programs. submission of this Allegation of Compliance within this timeframe in no way be considered or constr an agreement with allegations of noncompliance or admissions by the or any of its agents that the survey findings in this report are true or construed as an admission by the or any of its agents that the survey findings in this report are true or construed as an admission by the or any of its agents that the survey findings in this report are true or construed as an admission by the or any of its agents that the survey findings in this report are true or construed as an admission by the or any of its agents that the survey findings in this report are true or construed as an admission by the or any of its agents that the survey findings in this report are true or construed as an admission by the or any of its agents that the survey findings in this report are true or construction for the Medicaid and Medicare programs. On 9/24/2020, MDH completed a complaint survey and noted the fa failed to immediately report an alleg of staff to resident verbal abuse to state agency within two hours for residents (R2) reviewed for abuse is correcting this tag through the for interventions: Administrator will review policies a procedures regarding reporting of alleged abuse, neglect, or mistread	eement uth of ss of any nent by ne ed this ecause nd sion of n ten f icipation The should ued as the ot to be facility y agents orrect. or the les of cility egation the 1 of 3 c. Facility ollowing and all	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00770	B. WING		C 09/24/2020
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
ΙΑΥΟ C	LINIC HEALTH SYST	EM . LAKE CITY	T GRANT ST FY, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLE
21995	Continued From pa	ge 3	21995		
	The administrator s report any allegatio expect the report to within 2 hours of the The Vulnerable Adu dated 4/19 included skilled nursing facili violations involving mistreatment, inclu- source and misapp are reported, and a no later than 2 hour if the events that ca abuse or result in s than 24 hours if the allegation do not im in serious bodily inji facility and to other State Law through of SUGGESTED MET The administrator of procedures regardi abuse/neglect/mistri and or designee, co policies and proced develop a monitorir compliance.	s after the incident occurred. tated he would expect staff to n of abuse timely and would be filed to the state agency e occurrence. Alt - Abuse Prohibition Plan d, "Mandated reporters in ities ensure that all alleged abuse, neglect, exploitation or ding injuries of unknown ropriation of resident property, report made immediately, but rs after the allegation is made, use the allegation involve erious bodily injury, or no later events that cause the volve abuse and do not result ury, to the administrator of the officials in accordance with established procedures." THOD OF CORRECTION: could review policies and ng reporting of all alleged reatment. The administrator could re-educate all staff on the lures. The administrator could ng system to ensure ongoing R CORRECTION: Twenty one		mistreatment will be reported to the agency within two hours. Administrator or designee will re-educe staff on the two hour timeframe for reporting allegations of abuse, neg mistreatment. Staff will be re-educe the company policy and procedure surrounding such allegations. Educe will be completed by 10/30/2020. Audits will be conducted weekly for months and randomly thereafter for months to ensure allegations of ab neglect, or mistreatment are report within two hours. Results of the au- be reviewed at the Quality Assuran Committee for follow up and recommendations to ensure ongoin compliance and those solutions are sustained. Administrator will be responsible to compliance.	ducate lect, or ated on s cation r two r three use, ted dits will nce

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If continuation sheet 4 of 4