

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered January 21, 2022

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

RE: CCN: 245218 Cycle Start Date: December 9, 2021

Dear Administrator:

On January 13, 2022, the Minnesota Department of Health 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.

Mi This

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 22, 2021

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

RE: CCN: 245218 Cycle Start Date: December 9, 2021

Dear Administrator:

On December 9, 2021, 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 to the CMS Region V Office that one or more of the following remedies be imposed:

Mayo Clinic Health System - Lake City December 22, 2021 Page 2

- 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:

Annette Winters, Rapid Response Unit Supervisor Metro 1, Golden Rule Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: annette.m.winters@state.mn.us Mobile: (651) 558-7558

## 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 March 9, 2022 (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).

Mayo Clinic Health System - Lake City December 22, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by June 9, 2022 (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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html

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,

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Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

							APPROVED
		& MEDICAID SERVICES				1	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ´			COM	E SURVEY IPLETED
		245218	B. WING_				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	00 WEST GRANT STREET		
	INIC HEALTH SYSTE	M - LAKE CITY		L	AKE CITY, MN 55041		
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F 000	INITIAL COMMENT	ſS	F 00	00			
	survey was conduct was found to be NC requirements of 42 Requirements for L The following comp SUBSTANTIATED: with deficiencies cit	/9/21, a standard abbreviated ted at your facility. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities. laints was found to be H5218040C (MN00079076), ed at F604, and F758.					
	as your allegation o Departments accep enrolled in ePOC, y at the bottom of the form. Your electroni be used as verificat	f correction (POC) will serve f compliance upon the ptance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 604 SS=D	onsite revisit of you validate that substa regulations has bee Right to be Free fro	r facility may be conducted to ntial compliance with the en attained. m Physical Restraints	F 60	04			1/11/22
	§483.10(e) Respec The resident has a and dignity, includin	right to be treated with respect					
	physical or chemica purposes of discipli	right to be free from any al restraints imposed for ne or convenience, and not e resident's medical symptoms, 3.12(a)(2).					
	§483.12 The resident has th	e right to be free from abuse,					
		ER/SUPPLIER REPRESENTATIVE'S SIGN					(X6) DATE
		LIVOULLER REFREDENTATIVE DOLL	VALUKE		TITLE		
Electron	ically Signed						12/30/2021

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.

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

					APPROVE
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVE COMPLETED	
	245218	B. WING			09/2021
ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		00/2021
INIC HEALTH SYSTE	EM - LAKE CITY		500 WEST GRANT STREET LAKE CITY, MN 55041		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETIO DATE
neglect, misapprop and exploitation as includes but is not I corporal punishmen any physical or che treat the resident's §483.12(a) The fac §483.12(a)(2) Ensu from physical or ch purposes of discipli are not required to symptoms. When t indicated, the facilit alternative for the le document ongoing restraints. This REQUIREMEN by: Based on observat review, the facility f (R1) right to be free restraints when sta freedom of movem injected an antipsyc consent nor attemp interventions prior t medication. Findings include Facility Reported In State Agency on 12 of manual or physic the incident include while another nurse	riation of resident property, defined in this subpart. This limited to freedom from nt, involuntary seclusion and emical restraint not required to medical symptoms. ility must- ure that the resident is free emical restraints imposed for ine or convenience and that treat the resident's medical he use of restraints is ty must use the least restrictive east amount of time and re-evaluation of the need for NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 3 residents e from physical/chemical ff surrounded R1 preventing ent, held R1's arms and chotic medication without R1's oting any non-pharmacological to the administration of the	F 60	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, Administrato Employees, Agents or other indiv who draft or may be discussed ir Allegation of Compliance. In add preparation and submission of the Allegation of Compliance does no constitute an admission or an ag of any kind by the Facility of the t any facts alleged or the correctne conclusions set forth in the State the survey agency. Accordingly, f	ement of ind is also sion r, of any viduals n the ition, ne ot reement ruth of ess of any ment by the ted this	
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER INIC HEALTH SYSTI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par neglect, misapprop and exploitation as includes but is not l corporal punishmen any physical or che treat the resident's §483.12(a) (2) Ensu from physical or che purposes of discipil are not required to symptoms. When t indicated, the facilita alternative for the la document ongoing restraints. This REQUIREMED by: Based on observar review, the facility f (R1) right to be free restraints when sta freedom of movem injected an antipsyc consent nor attemp interventions prior to medication. Findings include Facility Reported In State Agency on 12 of manual or physic while another nurse	F CORRECTION       IDENTIFICATION NUMBER:         245218         245218         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.         §483.12(a) The facility must-         §483.12(a) (2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.         This REQUIREMENT is not met as evidenced by:       Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R1) right to be free from physical/chemical restraints when staff surrounded R1 preventing freedom of movement, held R1's arms and injected an antipsychotic medication without R1's consent nor attempting any non-pharmacological interventions prior to the administration of the medication.         Findings include       Facility Reported Incident (FRI) submitted to the State Agency on 12/6/21, at 1:34 p.m. alleged use of manual or physical restraint. The description of the incident included, "2 nurses held resident [R1] while another nurse gave injection through clothing, did not explain to resident injection	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTI A. BUILDIN         245218       B. WING	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         245218       B. WING         ROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 1 neglect, misappropriation of resident property, and exploitation as define in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.       F 604         §483.12(a) (2) Ensure that the resident is free from physical or chemical restraints is indicated, the facility must- gestanits. When that use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R1) right to be free from physical/chemical restraints when staff surrounded R1 preventing freedom of movement, held R1's arms and injected an antipsychotic medication without R1's consent nor attempting any non-pharmacological interventions.       Submission of this Allegation of Compliance is not a legal admiss deficiency exists or that this State and the facility Administration of the antipeychotic compliance does of manual or physical restraint. The description of the incident included, "2 nurses held resident [R1] while another nurse gave inje	MENT OF HEALTH AND HUMAN SERVICES       FORM         SFOR MEDICARE & MEDICAID SERVICES       OMB NO.         or DEFICIENCIES       OMB NO.         or DEFICIENCIES       OMB NO.         a survey and the servey and servery andery servery andery. Accordingly, the servery an

Facility ID: 00770

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	-	AND HUMAN SERVICES				FORM	06/01/2022 APPROVED 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245218	B. WING				C 09/2021		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
MAYO CI	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 604	State Agency on 12 diagnosis of anxiety with behavioral dist and restlessness are became angry that this anger and sweat Registered nurse (F her room until after and followed a nigh was leaving. R1's b and swearing to the RN-A. R1 was calm 1:1, R1 was ambulat dining room when lit (LPN)-A redirected R1 could eat breakt while eating breakfa R1 attempted to go swearing and yelling son. LPN-A redirect toileting, R1 compli- swearing during this R1's unit began hav at this time. RN-A of (anti-psychotic) intra- emergency room (E room, RN-A and LP while LPN-B admin R1's clothing. After swinging her walked The report indicated	ge 2 e summary submitted to the //10/21, included R1 had /, major depression, dementia urbance, confusional arousals, nd agitation. On 12/4/21, R1 she could not talk to her son, aring began at 6:00 a.m. RN)-A asked R1 to go back to morning report, R1 did not t nurse down hallway as he ehavior continued with yelling e point a 1:1 was decided by n for a period of time with a ating with walker towards icensed practical nurse R1 into the activity room so fast. No behavior outburst ast. After R1 was done eating, into the dining room, R1 was g about not talking with her ted R1 to her room for ed but was yelling and s time. Other residents on the ving concerns for their safety obtained an order for Haldol amuscular (IM) and send to ER). As R1 came out of the PN-A took hold of R1's arms istered the IM Haldol through the injection R1 began r striking LPN-A and RN-A. d staff had informed R1 her to see R1, R1 calmly walked to	F	604	Federal law that mandate submissi an Allegation of Compliance within days of receipt of the Statement of Deficiencies as a condition of partic in Title 18 and Title 19 programs. T submission of this Allegation of Compliance within this timeframe s in no way be considered or constru an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is no construed as an admission by the f or any of its agents that the survey findings in this report are true or co The plan of correction is written for purpose of compliance with the rule participation for the Medicaid and Medicare programs. R1, care plan reviewed and revised Education provided to nursing staff 12/7/2021 regarding documentation electronic behavior note , and polic which included Vulnerable Adult an Restraint which included physical a chemical restraint. 12/21/2021 beha education regarding documentation behavior note template. Education continues to be provided staff regarding restraints policy and Vulnerable adult policy. Lake City Care Center to monitor its corrective actions by conducting we psychotropic interdisciplinary meeti review of identified residents which includes ensuring consents, non-pf	ten cipation he hould ed as ne t to be acility agents rrect. the es of d n of the ies d nd avioral n of the i to all l seekly ng with			
	11/4/21, indicated F	num Data Set (MDS) dated R1's brief interview for mental 2, which indicated moderate			medications, effectiveness, behavior documentation, prn and scheduled psychotropic medications. Findings	oral			

Facility ID: 00770

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		IPLETED
		245218	B. WING			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP		
MAYO C	LINIC HEALTH SYSTI	EM - LAKE CITY		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 PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 604	• • • • • • • • • • • • • • • • • • •	-	F 6			
	not have symptoms verbal or physical b R1 did not requires	nt. The MDS indicated R1 did s of delirium and did not have behaviors. The MDS identified staff assistance for bed nd locomotion on and off the bindicated R1 was		the meeting will be reported meeting for evaluation and Deficiency to be corrected 11th, 2022. Director of Nursing respon	d feedback. I on January	
	administered antide	epressant and antipsychotic luring the assessment period.		compliance.		
	STAT doses of Ser	ers on 12/4/21, included the oquel and Haldol, physician ide orders for physically he administration.				
	individualized beha plan did not include use intimidation an antipsychotic medic to give medications consent prior to ad included, "[R1] may times when she be utilize physicians' of for follow up." and violent and un-redin security or the loca her to the ER for ev	ed 11/11/21, identified vioral interventions; the care e, identify, or instruct staff to d/or restraints to administer cation, and did not direct staff s without first obtaining R1's ministering. The care plan y refuse her medications at comes agitated. Staff are to orders or call on call provider "If [R1] becomes physically rectable, staff are to call I police department to assist valuation. Charge nurse to ine when necessary."				
	7:00 a.m. R1 was a staff wanting to talk the on-call physicia behavior continued increase Seroquel note included, "Res dose." The note inc	dated 12/4/21, indicated at agitated, yelling/screaming at to her son. The nurse called in at 7:15 a.m. when the ; physician gave order to and add as needed dose. The sident did take increased dicated R1 continued to yell ited to see her son, and R1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FC	ORM APPROVED	
	DMB NO. 0938-0391	
	B) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NOMBER. A. BUILDING		
	С	
245218 B. WING	12/09/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO CLINIC HEALTH SYSTEM - LAKE CITY		
LAKE CITY, MN 55041		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
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 APPROPRIATI	COMPLETION DATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E 5/112	
F 604Continued From page 4F 604		
started to yell at residents as R1 walked down		
hallways. In addition, R1 threatened staff by		
holding her fist up and pushed staff with her		
walker. "On call [physician] was called and		
updated with new order of IM [intramuscular]		
injection to be administered STAT. 4 staff was		
able to give injection."		
During entrance conference on 12/8/21, at 10:23		
a.m. the administrator and interim director of		
nursing (IDON) were interviewed regarding the		
submitted FRI. The IDON stated she had come		
into work the morning of 12/6/21, and was looking		
for a report for stand-up meeting and saw that R1		
had transferred to the hospital. IDON stated she		
looked for more specific information and found a		
progress note that it took four nurses to		
administer an IM injection. IDON stated she		
started investigating immediately and once she		
interviewed and found out what happened, she		
knew it was a vulnerable adult incident and made		
a report to the State Agency as quickly as		
possible. IDON stated the incident happed on		
12/4/21, and stated the progress notes lacked		
specific information about the timing of the		
sequence of events. IDON indicated so far in her		
investigation she had found, R1's behaviors		
started at 6:15 a.m., RN-A had obtained an order		
for an extra dose of Seroquel around 7:15 a.m.,		
LPN-A administered the medication without R1's		
consent and without attempt of care plan		
interventions, R1's behaviors of yelling continued		
and became increasingly agitated, RN-A obtained IM Haldol order, and while 3 other nurses		
surrounded her by the entrance of her room, RN B injected the Haldol into R1's buttock		
RN-B injected the Haldol into R1's buttock through her clothing without R1's knowledge and		
two nurses held R1's arms. IDON indicated the		

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	06/01/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245218	B. WING	i				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COI	)E		
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY			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 PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 604	hospital was not ide indicated RN-B was of R1, RN-A and LF physically restrained asked LPN-B what warranted the inject not enough to give there was no redire yelling, she [R1] did injection was given nurses involved rep that using physical accordance with the against facility polic standard that was s IDON stated the fac physical restraints a jeopardy of harming should have called stated the Seroque have been administ a means to attempt instead care plan in offered and attempt During an interview LPN-A stated arour informed R1 require because she was h R1 was very agitate about wanting to ca walked down hallwa could not allow R1 f plan. LPN-A indicat	hat R1 transferred to the entified in the record. IDON is the nurse who stood in front PN-A were the nurses who d R1's arms. IDON stated she R1 was doing at the time that tion, and IDON stated, "Was a Haldol injection. Honestly ction, she was cursing and In't start hitting until after " IDON indicated the three forted they had not recognized restraints was not in the standards of practice and y because that was not the set by the previous DON. cility does not endorse or use and if staff thought R1 was in g herself and others they 911 for assistance. IDON I and IM Haldol should not tered without R1's consent and to control R1's behaviors, iterventions should have been	F	504	DEFICIENCY)			
	indicated R1's yellir	vever, this did not work. LPN-A ng behaviors were starting to ner residents. LPN-A stated as						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	): 06/01/2022 APPROVED ). 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245218	B. WING			12	/09/2021	
	PROVIDER OR SUPPLIER	EM - LAKE CITY		500 <b>\</b>	ET ADDRESS, CITY, STATE, ZIP COL WEST GRANT STREET E CITY, MN 55041	i		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 604	R1 walked around distance to make siverbally assault rest R1 went to her room RN-B] walked down out of her room. LF surrounded R1 out trying to get her bahe was on R1's right R1's left side, and indicated R1 had baggressive manner thought was standin indicated at some pR1's arm to prevent sure if the hold hap administered the mall happened so fast injection was given however, staff were adjacent emergend while R1 was surrounded R1 and preventing the injection was a manual physistanding up and no stated a similar praticated at at	age 6 yelling, he followed from a sure R1 did not physically or sidents. LPN-A indicated when m, they [RN-A, LPN-B, and n to R1's room, as R1 walked PN-A indicated staff had side her doorway and were ck into her room. LPN-A stated ht side, thought RN-A was on LPN-B was behind R1. LPN-A een pushing her walker in an r towards RN-B who he ng in front of R1. LPN-A point he physically grabbed at movements and was not opened before or after LPN-B nedication for sure because it st. LPN-A indicated after the R1 continued to yell/scream, e able to escort R1 to the cy department. LPN-A indicated punded by staff, R1's care plan ehavioral management were npted. LPN-A indicated an did not identify that surrounding her from walking away to give type of restraint. LPN-A t think holding onto R1's arms sical restraint because R1 was of lying down in bed. LPN-A actice had been used before on ous DON was there (about a ght the practices were /6/21, when he was informed lucation by the IDON.		04				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 06/01/2022 APPROVED . 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/09/2021		
		245218	B. WING				
	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	(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 604	walking around her and screaming abo son, R1 was scarin providing 1:1 to ma safe from R1. LPN were directed towa physically and/or vo LPN-B stated RN-A Haldol between 7:3 stated she drew the volunteered to give and scared. LPN-B room, and they (RN trying to get R1 to g made R1 get even RN-A was on R1's her left side, RN-A RN-A directed her and give R1 the injection around with her wa awareness that RN but was not able to LPN-A and RN-A h LPN-B indicated at wrong doing by sur restraining R1's pants previous practice. I aware until Monday had provided educt policy. During an interview stated she was the 12/4/21. RN-A state	age 7 • unit and the other unit yelling but not being able to call her ig other residents. LPN-A was ake sure other residents were -A thought R1's behaviors rd staff and did not observe R1 erbally abusing other residents. A had obtained an order for IM 80 a.m. and 8:30 a.m LPN-B e medication up and e it which made her nervous 8 stated R1 had gone into her N-A, LPN-A, and RN-B) were go back into her room, which madder. LPN-B indicated right side and LPN-A was on was in front. LPN-B stated to come around the doorway ection. LPN-B indicated she on in her left buttock through stated she did not ask or inform first and stated R1 tried to turn lker. LPN-B stated an I-A and LPN-A held onto R1 a rticulate how or at what point ad restrained R1's arms. the time she did not identify rounding R1, physically ms, and injecting medication because that had been the _PN-A stated she was not y 12/6/21, when administration ation and informed her of the	F 604				

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		AND HUMAN SERVICES			FORM	06/01/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED	
		245218	B. WING _		C 12/09/2021		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·		
MAYO CI	LINIC HEALTH SYSTE	EM - LAKE CITY		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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 604	6:30 a.m. RN-A ind continued, RN-A ind assaulted and/or ha was disruptive and walked around her indicated around 7: Seroquel without R no effect, she called and got an order fo went into her room R1 started exiting h went behind R1 and startled R1. R1 pick back toward LPN-B arms around R1's a striking out. RN-A s 15 to 30 seconds. F yell/scream at staff however, R1 was a adjacent emergence that her son was wa indicated an unawa policies pertaining t and manual holds b acceptable practice stated she had rece During an observat at 4:30 p.m. R1 sat stated things were fall the other day wi mention her son an behaviors. R1 stood her walker, and wal unidentified nurse, R1, explained she y	ge 8 as they left the building around icated R1's behaviors dicated R1 had not physically armed other residents but, R1 scaring other residents as she unit and the other unit. RN-A 15 she had administered the 1 knowing, it seemed to have d the physician a second time r IM Haldol. RN-A indicated R1 to use the bathroom, and as ther room, that is when LPN-B d gave R1 the injection, which ced up her walker and turned b. RN-A and LPN-B laced their arms preventing her from tated they held R1's arms for RN-A stated R1 continued to for about 20-30 minutes, greeable to walk to the y room after staff informed R1 aiting for her there. RN-A reness of the facility's restraint o medication administration because it had been an e of the previous DON. RN-A aived re-education on 12/8/21, in a chair in her room. R1 going fine except she had a hile at the hospital, did not d/or of verbal/physical d up with socks on, grabbed ked out into the hallway to was concerned because R1 on and did not want her to fall. the nurse to escort her back	F 60	)4			

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		FORM	06/01/2022 APPROVED 0938-0391					
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				PLETED
		245218	B. WING					09/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP COL	)E		
MAYO CI	LINIC HEALTH SYSTE	EM - LAKE CITY			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	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 604	Continued From pa into her room. During an interview	ge 9 on 12/8/21, at 6:37 p.m.	F 6	604				
	RN-B stated on 12/ 6:00 a.m. and was behaviors had start R1's unit. RN-B inc had walked over to and saw/heard R1 y	4/21, she had started work at not sure what time R1's yelling ed because she was not on licated around 7:30 a.m. R1 the unit she was working on yelling at LPN-A. RN-B stated bund the nursing units yelling						
	and screaming at s her son. RN-B indic disruptive and aggr staff had provided 1 residents were not around 8:30 a.m. R	taff about wanting to talk to eated because of R1's essive behaviors toward staff, I:1 supervision to assure other harmed. RN-B indicated 1 continued to yell/scream ined an order for IM Haldol.						
	RN-B stated when s LPN-B with the Hale down the hallway ba following her from a when R1 was exitin standing around he	she got over to R1's unit with dol injection, R1 was walking ack to her room with RN-A a short distance. RN-B stated g her room and staff were r. RN-B asked R1 to go back 1 told her no. RN-B stated she						
	then asked R1 why and R1 got in her fa thought she was go when LPN-B must I R1 turned and look she had given her a	she was so upset with them, ace. R1 did not hit her but she ing to. RN-B stated that is nave given R1 the injection, as ed down and asked LPN-B if a shot. RN-B indicated LPN-A						
	from striking out or Facility policy Restr dated 4/2018 includ facility to ensure a r shortest duration po and review of devic	bed R1's arms to keep her to stabilize her. aint-Physical Device, Use of led, It is the policy of the restraint is utilized for the ossible, resident is comfortable es on admission, quarterly, ge in status, and when a						

If continuation sheet Page 10 of 20

STATE PLAN OF CORRECTION       (X) IDENTIFICATION NUMBER:       (Z) NULTIFIE CONSTRUCTION       (Z) NU			AND HUMAN SERVICES					FORM	APPROVED 0938-0391
C       245218       B WING       C       12/09/2021       NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       500 WEST GRANT STREET       LAKE CITY       C       MAYO CLINIC HEALTH SYSTEM - LAKE CITY       SUMMARY STATEMENT OF DEFICIENCIES       PREFIX       COMPONEDRS PLAN OF CORRECTION       (EACH DEFICIENCY MUST DE PRÉCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PID       PREFIX     Continued From page 10     PREFIX     CROSS-REFERENCE TO THE APPROPRIATE       DEFICIENCY     DEFICIENCY     DEFICIENCY     CONVENIENCE OF FACILITY STAFF. The DEFICIENCY       MEDICAL AND NURSING CARE OR FOR THE CONVENIENCE OF FACILITY STAFF. The procedure directed the following: 1) if the device use is deemed necessary, the goal will be to use the least restrictive type of device for the shortest period of time possible. 3) A physical dvice for the shortest period symptom) and duration of application. Free from Unnee Psychotropic Meds/PRN Use SS=D     F 758     1/11/22       S483.45(c)(3) A, Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (I) Anti-apsychotic; (II) Anti-depressant; (III) Anti-apsychotic; (II) Anti-depressant; (III) Anti-depressant; (III) Anti-depressant; (IIII) Anti-depres	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /				(X3) DAT	E SURVEY
245218         B. WING         12/09/2021           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041         STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041         SOUMARY STATEMENT OF DEFICIENCES FOR USE OF DEFICIENCY MUST BE PROCEEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PRETX FAG         STREET ADDRESS, CITY, STATE, ADPROPRIATE DEFICIENCY         COME ADDRESS FLAN OF CORRECTION (EACH CORRECTED ACTION HOULD BE COME ADDRESS FLAN OF CORRECTION (EACH CORRECTED ACTION HOULD DE DEFICIENCY)         COME ADDRESS FLAN OF CORRECTION (EACH CORRECTED ACTION HOULD DE DEFICIENCY)         COME ADDRESS (EACH CORRECTION HOULD DE DEFICIENCY)         COME ADDRESS (EACH CORRECTION HOULD DE DEFICIENCY)         COME ADDRESS FLAN OF CORRECTION (EACH CORRECTED ACTION HOULD DE DEFICIENCY)         COME ADDRESS (EACH CORRECTION HOULD DE DEFICIENCY)         COME ADDRESS (EACH CORRECTED ACTION HOULD DE DEFICIENCY)         COME ADDRESS (EACH CORRECTED ADDRESS (EACH CORRECTED ADD	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING				
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       MAYO CLINIC HEALTH SYSTEM - LAKE CITY     STREET ADDRESS, CUTY, STATE, ZIP CODE       F604     Continued From page 10     F 604       Interapeutic is being considered and trialed.     NOTE: RESTRAINTS OF ANY TYPE WILL NOT       BE USED AS PUNISHMENT OR AS A     SUBSTITUTE FOR MORE EFFECTIVE       MEDICAL AND NURSING CARE OR FOR THE     CONVENIENCE OF FACILITY STAFF. The       procedure arestrictive type of device, specific reason     Interapeutics       a physical device restraint is required and must     SAB3.45(c)(3) A psychotropic Mugs <td></td> <td></td> <td>245218</td> <td>B. WING</td> <td></td> <td></td> <td></td> <td></td> <td></td>			245218	B. WING					
MAYO CLINIC HEALTH SYSTEM - LAKE CITY         LAKE CITY, MN 55041           (M) ID PREFX TAG         SUMMARY STATEMENT OF DEFICENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFX REGULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDENCING CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         000 DEFICIENCY           F 604         Continued From page 10 therapeutic is being considered and trialed. NOTE: RESTRAINTS OF ANY TYPE WILL NOT BE USED AS PUNISHMENT OR AS A SUBSTITUTE FOR MORE EFFECTIVE MEDICAL AND NURSING CARE OR FOR THE CONVENIENCE OF FACILITY STAFF. The procedure directed the following: 1) if the device use is deemed necessary, the goal will be to use the least restrictive type of device for the shortest period of time possible. 3) A physician's order for a physical device restraint is required and must specify the type of device, specific reason (medical symptom) and duration of application. F 758         F 758         1/11/22           SUBSED SS=D         CFR(s): 483.45(c)(3)(a)(1)-(5)         F 758         F 758         1/11/22           S483.45(c)(3) A psychotropic Drugs. S483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (I) Anti-apsychotic; (II) Anti-anxiety; and (IV) Hypnotic         F 838.45(c)(1) Residents who have not used psychotropic drugs are not given these drugs         F	NAME OF F	PROVIDER OR SUPPLIER					CODE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSSREPTERCOT OT THE APPROPRIATE DEFICIENCY)       COMMENTION DATE         F 604       Continued From page 10 therapeutic is being considered and trialed. NOTE: RESTRAINTS OF ANY TYPE WILL NOT BE USED AS PUNISHMEENT OR AS A SUBSTITUTE FOR MORE EFFECTIVE MEDICAL AND NURSING CARE OR FOR THE CONVENIENCE OF FACILITY STAFF. The procedure directed the following: 1) if the device use is deemed necessary, the goal will be to use the least restrictive type of device for the shortest period of time possible. 3) A physician's order for a physical device restraint is required and must specify the type of device, specific reason (medical symptom) and duration of application. F rots       F 758       1/11/22         SS=D       CFR(s): 483.45(c)(3)(e)(1)-(5)       F 758       1/11/22         §483.45(c)(3) A psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-psychotic; (iii) Anti-anxiety; and (iv) Hypnotic       F 758         Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	MAYO CI	LINIC HEALTH SYSTE	M - LAKE CITY						
therapeutic is being considered and trialed.       NOTE: RESTRAINTS OF ANY TYPE WILL NOT         BE USED AS PUNISHMENT OR AS A         SUBSTITUTE FOR MORE EFFECTIVE         MEDICAL AND NURSING CARE OR FOR THE         CONVENIENCE OF FACILITY STAFF. The         procedure directed the following: 1) if the device         use is deemed necessary, the goal will be to use         the least restrictive type of device for the shortest         period of time possible. 3) A physician's order for         a physical device restraint is required and must         specify the type of device, specific reason         (medical symptom) and duration of application.         F 758       Free from Unnec Psychotropic Meds/PRN Use         SS=D       CFR(s): 483.45(c)(3)(e)(1)-(5)         §483.45(c)(3) A psychotropic Drugs.         §483.45(c)(3) A psychotropic drug is any drug that         affects brain activities associated with mental         processes and behavior. These drugs include,         but are not limited to, drugs in the following         categories:         (i) Anti-psychotic;         (iii) Anti-anxiety; and         (iv) Hypnotic         Based on a comprehensive assessment of a         resident, the facility must ensure that         §483.45(e)(1) Residents who have not used         psychotropic drugs	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD	BE	COMPLETION
in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758	therapeutic is being NOTE: RESTRAIN BE USED AS PUNI SUBSTITUTE FOR MEDICAL AND NUL CONVENIENCE OF procedure directed use is deemed neod the least restrictive period of time possi a physical device re- specify the type of of (medical symptom)) Free from Unnec PE CFR(s): 483.45(c)(3) §483.45(c)(3) A psy affects brain activiti processes and behave but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compre- resident, the facility §483.45(e)(1) Resid psychotropic drugs unless the medicati specific condition as in the clinical record §483.45(e)(2) Resid	considered and trialed. TS OF ANY TYPE WILL NOT SHMENT OR AS A MORE EFFECTIVE RSING CARE OR FOR THE FACILITY STAFF. The the following: 1) if the device essary, the goal will be to use type of device for the shortest ible. 3) A physician's order for estraint is required and must device, specific reason and duration of application. sychotropic Meds/PRN Use B)(e)(1)-(5) ropic Drugs. rohotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following d thensive assessment of a must ensure that dents who have not used are not given these drugs on is necessary to treat a s diagnosed and documented d; dents who use psychotropic						1/11/22

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		AND HUMAN SERVICES			FOF	D: 06/01/2022 MAPPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X3) D	(X3) DATE SURVEY COMPLETED	
		245218	B. WING	ə	1	C 2/09/2021	
NAME OF F	PROVIDER OR SUPPLIER	1	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY			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 PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	behavioral intervent contraindicated, in a drugs; §483.45(e)(3) Resid psychotropic drugs unless that medicat diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the beyond 14 days, he rationale in the resi indicate the duratio §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitic the appropriateness This REQUIREMEN by: Based on observat	tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and orders for psychotropic drugs ys. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their dent's medical record and n for the PRN order. orders for anti-psychotic 14 days and cannot be e attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced tion, interview, and document ailed to document, monitor,	F	758	Submission of this Allegation of Compliance is not a legal admission that deficiency exists or that this Statement of		
	non-pharmacologic interventions for tar identified for antips residents (R2, R3) management. Findings include R2's quarterly Minir	num Data Set dated 11/10/21, noderate cognitive impairment,			deficiencies was correctly cited and is all not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of	so /	

Facility ID: 00770

If continuation sheet Page 12 of 20

						. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION		E SURVEY IPLETED
						С
		245218	B. WING _			09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	· · ·	
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY		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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 758	Continued From pa	ige 12	F 75	58		
	did not have signs/s rejection of care be R2 was administered antidepressant med assessment period R2's care plan date diagnoses of major dementia with beha anxiety disorder. R2 used psychotropic aforementioned dia target behaviors; Ta sleeplessness Cym pain Seroquel 4. ho others 6. delirious s care plan directed s non-pharmacologic mood/behavior plan monitor, and evalua and effectiveness. a "mood and behavior R2's target behavior R2 had delirium or which the care plan provide gentle reali Reorient to person, required. R2's depr staff to administer r encourage activities in. R2's physician order identified R2's curre included: -Seroquel (antipsyce	symptoms of delirium, and had thaviors. The MDS identified ed antipsychotic and dications during the		<ul> <li>any facts alleged or the conclusions set forth in the the survey agency. Accord Facility has prepared and Allegation of Compliance s of the requirements under Federal law that mandate an Allegation of Compliance and Allegation of Compliance and Allegation of Compliance and Allegation of Compliance days of receipt of the State Deficiencies as a condition in Title 18 and Title 19 prosubmission of this Allegati Compliance within this tim in no way be considered o an agreement with allegat noncompliance or admissi facility. This plan of correct construed as an admission or any of its agents that the findings in this report are to The plan of correction is we purpose of compliance with participation for the Medica Medicare programs.</li> <li>R2 care plan updated to ir and behavior, non-pharmatinterventions for target bel R3 Care plan and medical reviewed and updated to redication consistent with orders and target behavior etar includes behaviors, nupharmacological interver Review of resident behaviors, nupharmacological interver Review of resident behaviors and target behavior and behaviors and target behaviors and target</li></ul>	e Statement by lingly, the submitted this solely because State and submission of ce within ten ement of n of participation grams. The on of eframe should r construed as ons of ons by the tion is not to be n by the facility e survey agents rue or correct. ritten for the h the rules of aid and acclude mood icological naviors, triggers. record effect care plan physician rs. ving nsure resident on ntions. oral hift to shift.	

Facility ID: 00770

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		AND HUMAN SERVICES			F	FORM	06/01/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	COMF	SURVEY
		245218	B. WING			C 12/0	<i>,</i> 9/2021
NAME OF I	PROVIDER OR SUPPLIER	I	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTI	EM - LAKE CITY			00 WEST GRANT STREET AKE CITY, MN 55041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	-Buspirone (anxioly times a day for anx -Duloxetine (antide two times a day for -Trazodone (antide one time a day for -Trazodone (antide behaviors with char monitor/document medications. R2's physician note "Nursing to chart of behaviors qshif [ev examples of agitati be harmful to reside that cause interfere Review with NP/PA assistant] in 2 week R2's behavioral rec 11/19/21 to 12/9/21 documentation of F lacked evidence no interventions were offered and when in documented, the re effectiveness. Exar included: -Progress note data "Resident is unhap go home. Refused drink any ensure [d only water. -Progress note data observed anxiousn in w/c [wheelchair]	tic medication) 30 mg two iety. pressant medication) 30 mg anxiety. pressant medication) 25 mg insomnia/depression. ers also identified target rt codes for staff to for associated psychotropic e dated 11/16/21 included, n patient's mood and ery shift], with specific on, or any behaviors that may ent, staff or other residents, or ence in caring for the patient. I [nurse practitioner/physician ks." cord was reviewed between , although the record reflected R2's behaviors, the record on-pharmacological consistently attempted or nterventions were ecord lacked evaluation of mples from R2's record ed 11/19/21, included, py with staying here, wants to to eat dinner and refused to lietary nutritional supplement], ed 11/21/21, included, "No ess. Resident withdrawn. Up	F 7	758	staff VA education. Additional policy psychopharmacologic drug use. At least quarterly comprehensive psychotropic assessments of residem receiving psychotropic medications. Lake City Care Center to monitor its corrective actions by conducting weel psychotropic interdisciplinary meeting review of identified residents which includes ensuring consents, non-phar medications, effectiveness, behaviora documentation, prn and scheduled psychotropic medications. Findings fi the meeting will be reported at the QA meeting for evaluation and feedback. Random audits to include POC behave documentation, behavioral monitoring interventions report, behavioral nurse note up to 3x a week x 3 months. Fir from audits will be reported at the mo QAPI meeting for additional feedback evaluation. Deficiency to be corrected on January 11th, 2022 Director of nursing responsible to ens compliance.	kly g with al from API vioral g and es nding onthly k and	

If continuation sheet Page 14 of 20

		AND HUMAN SERVICES				FORM	: 06/01/2022 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>		LE CONSTRUCTION	CON	TE SURVEY MPLETED
		245218	B. WING				/09/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY			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	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758	included, "This resi and hitting out when Staff have attempted continued to yell at changed required a -Progress note data included, "Resident shift." -Progress note data included, R2 was " anxious." -Progress note data included, "This resi staff assist and has vitals this shift." -Progress note data included, "Resident help with cares." -Progress note data included, "Resident help with cares." -Progress note data included, "Resident rounds check and o -Progress note data included, "Resident when assisting with R2's Point of Care documentation) wa 12/9/21, the docum behavior by a nume documentation lack non-pharmacologic offered when there The record also ide Examples included -On 12/1/21, POC of identified R2 had ba kicking/hitting and p	dent has been very resistive in staff attempt to help her. ad to redirect but she staff attempt to hit staff. Being issist of 2 this shift." ed 11/23/21 at 1:41 p.m. a refused to eat lunch this ed 11/23/21, at 10:17 p.m. listless, tired, obstinate but not ed 11/24/21, at 2:42 a.m. dent has been very resistive to a refused to let staff check her ed 11/25/21, at 2:31 p.m. a has been refusing to let staff ed 11/26/21, at 3:22 a.m. a hit staff during noc [night] change." ed 12/1/21, at 3:09 a.m. a was combative with staff b brief change." (POC-nursing assistant s reviewed between 12/1/21 to ientation only identified a erical code in a box. POC and evidence of cal interventions attempted or was charting of a behavior. entified multiple blank boxes.	F 7	758			

		AND HUMAN SERVICES				FORM	: 06/01/2022 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	CO	TE SURVEY MPLETED C
		245218	B. WING				/09/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAYO CI	INIC HEALTH SYST	EM - LAKE CITY			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 PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 758	Continued From pa	age 15	F 7	58			
	-On 12/3/21, boxes were blank. -On 12/4/21, boxes were blank. -On 12/5/21, boxes -On 12/6/21, boxes -On 12/6/21, boxes -On 12/8/21, POC identified R2 had b pinching/scratching R2's record lacked assessment and eve effectiveness of no interventions in cor psychotropic medic lowest therapeutic medications. During an interview registered nurse (F documentation and identify non-pharm or attempted. RN-Every descriptive an were supposed to b note and if those in During an observat R2 sat at the dining R2 did not display a During an interview	<ul> <li>a for day and evening shift</li> <li>a for day and evening shift</li> <li>a for all shifts were blank.</li> <li>a for all shifts were blank.</li> <li>b for all shifts were blank.</li> <li>c for all shifts were blank.</li> <li>b for all shift was blank.</li> <li>b for all shifts were blank.</li> <li>b for all shifts were blank.</li> <li>b for all shift were blank.</li> <li>c on 12/9/21, at 12:14 p.m.</li> <li>c on 12/9/21, at 12:22 p.m.</li> <li>g room table in her wheelchair, any behaviors.</li> </ul>					
	director of nursing currently did not ha interdisciplinary con medications and/or the facility worked	(IDON) indicated the facility					

If continuation sheet Page 16 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3	IB NO. 0938-0391 X3) DATE SURVEY COMPLETED
	COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	С
245218 B. WING	12/09/2021
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) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 758 Continued From page 16 F 758 medication use. IDON indicated an expectation that nursing assess the resident and evaluate for the root cause of what is causing the behavior. IDON stated nurses should be documenting interventions that were utilized so it could be determined if the interventions were working. R3's quarterly MDS dated 11/24/21, indicated R3 had severe cognitive impairment with no signs/symptoms of delirium, did not have hallucinations or delusions and did not have behaviors. The MDS identified R3 was administered antipsychotic and antidepressant medications during the assessment period. R3's care plan dated 11/30/21, indicated R3 had diagnoses of major depressive disorder, anxiety disorder, and dementia with behavioral disturbance. R3's mod and behavior care plan included, "Theve history of depression and anxiety for which I receive medications which included, Target behaviors to observe for Sercoule: A) Behaviors S1 hallucinations C) Delirium D) Wandering status. Bupropion: E) crying F) sad faces G) Isolating self. Buspione: H) calling out I) verbalizations of annot encluded individualized non-pharmacological interventions associated with the target behaviors. The care plan included at 51 for monitor/document Side effects and effectiveness of medication R3's physician orders dated 12/9/21, was inconsistent with the medications that were identified in the care plan dated 12/9/21, was inconsistent with the medication for these conditions. R3's physician orders dated 12/9/21, was inconsistent with the medication for serve for the recerve the other serve the other serve the other server to the recerve the server the recerve the other servers the servers	

If continuation sheet Page 17 of 20

		AND HUMAN SERVICES			FORI	D: 06/01/202 MAPPROVE D. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY
		245218	B. WING		1:	2/09/2021
	PROVIDER OR SUPPLIER L <b>INIC HEALTH SYSTI</b>	EM - LAKE CITY		STREET ADDRESS, CITY, 500 WEST GRANT STR LAKE CITY, MN 5504	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 758	included: -Seroquel (antipsyc milligrams (mg) in t bedtime for demen -Zoloft (antidepress per day for depress -Buspirone (anxioly per day for anxiety. R3's physician orde behaviors with char monitor/document medications. Medic behaviors were cor orders, however, w medications and th physician order with included charting c observe for Seroqu 3) wandering 4) Cry Zoloft 6) withdrawn statements directed behaviors occurred R3's behavioral rec 11/28/21 to 12/9/21 documentation of F lacked evidence the interventions were offered and when in documented, the re effectiveness. Exar included: -Progress note date included; "Resident another resident in [sic] resident threat throat. Resident ha	chotic medication) 12.5 the morning and 25 mg at tia with behavioral disturbance. sant medication) 100 mg once sion. tic medication) 20 mg twice ers also identified target rt codes for staff to for associated antipsychotic cations associated with target hisistent with the physician ere inconsistent with care plan e target behaviors. The h a start date of 7/19/21, odes for target behaviors to tel: 1) hallucinations 2) yelling ying Buspar 5) restlessness 7) anxious behavior 8) sexual d towards others 0) no l.	F 75	58		

		AND HUMAN SERVICES					FORM	06/01/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	0	(X3) DATE COM	E SURVEY PLETED
		245218	B. WING	i				C 09/2021
NAME OF I	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CC	DE		
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY			0 WEST GRANT STREET NKE CITY, MN 55041			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 758	causing this resider taken back to the u	ge 18 nt agitation. Resident was nit for supper meal. Charge	F	758				
	nurse updated." R3's Point of Care of documentation) wa to 12/9/21, the docu behavior by a nume documentation lack non-pharmacologic offered when there The record also ide Examples included -On 11/28/21, POC identified R3 had be and pushing. -On 12/3/21, POC of shift identified R3 had be -On 12/6/21, POC of identified R3 had be -On 12/7/21, POC of shift identified R3 had be -On 12/7/21, POC of shif	(POC-nursing assistant s reviewed between 11/28/21 umentation only identified a erical code in a box. POC ted evidence of ral interventions attempted or was charting of a behavior. entified multiple blank boxes. documentation for day shift ehaviors of yelling/screaming documentation for evening ad behaviors of pushing documentation for night shift ehaviors of pushing. documentation for evening						
		on 12/9/21, at 12:14 p.m. s behavioral documentation						

If continuation sheet Page 19 of 20

		AND HUMAN SERVICES				FORI	D: 06/01/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		245218	B. WING			1:	2/09/2021
NAME OF	PROVIDER OR SUPPLIER	l .		SI	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY			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	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 758	and confirmed their non-pharmacologic attempted. RN-B st very descriptive and were supposed to b note and if those in During an observat R3 sat at the dining R3 did not display a During an interview indicated the facility psychotropic interd reviewed medicatio indicated the facility DON stated they er psychotropic medic expectation that nu evaluate for the roc behavior. IDON stat documenting interview	record did not identify cal interventions offered or ated the behaviors were not d should be, interventions be documented in a progress terventions worked or not. ion on 12/9/21, at 12:22 p.m. room table in her wheelchair,	F 7	758			

Facility ID: 00770

If continuation sheet Page 20 of 20



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 22, 2021

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

Re: State Nursing Home Licensing Orders Event ID: 56J411

Dear Administrator:

The above facility was surveyed on December 8, 2021 through December 9, 2021 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 December 22, 2021 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:

Annette Winters, Rapid Response Unit Supervisor Metro 1, Golden Rule Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: annette.m.winters@state.mn.us Mobile: (651) 558-7558

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.

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00770	B. WING		12/0	) 9/2021
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 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 APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****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				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnoorte	conducted at your f Minnesota Departm facility was found N State Licensure. Pla plan of correction y and identify the date	TS: 9/21, a complaint survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			С
		00770	B. WING			09/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MAYO C	LINIC HEALTH SYSTE		T GRANT STF TY, MN 55041			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: with a licensing order The Minnesota Dep documenting the St Orders using Feder have been assigned statutes/rules for Net tag number appears "ID Prefix Tag." The compliance is listed of Deficiencies" coll Comply" portion of the column also include violation of the state "This Rule is not me the surveyor's findir of Correction and T You have agreed to receipt of State lice the Minnesota Depa Informational Bullet <https: www.health<br="">on/infobulletins/ib14 orders are delineate Department of Heal you electronically. A is necessary for State neter the word "CO available for text. Yo electronic State lice heading completion be corrected prior to the Minnesota Depa is enrolled in ePOC</https:>	laint was found to be H5218040C (MN00079076) er issued at 0505 and 1535. partment of Health is ate Licensing Correction ral software. Tag numbers d to Minnesota state ursing Homes. The assigned s in the far-left column entitled e state statute/rule out of l in the "Summary Statement umn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidence by." Following ngs are the Suggested Method ime Period for Correction. participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/facilities/regulati L1.html> The State licensing ed on the attached Minnesota th orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the date, the date your orders will o electronically submitting to artment of Health. The facility and therefore a signature is pottom of the first page of				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00770	B. WING			C 09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
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		LAKE CI	TY, MN 55041			
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	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 505	MN Rule 4658.0300 Restraints	0 Subp. 1 A-E Use of	2 505			1/11/22
		ons. For purposes of this part, have the meanings given.				
	method or physical material, or equipm the resident's body remove easily which movement or norm. Physical restraints in leg restraints, arm r or vests, and wheel restraints also incluid definition of a restra so tightly that a resident placing a resident in wall that the wall pro- rising. Bed rails are restrict freedom of used solely to assiss help the resident ge is not used as a resident not, in and of thems	straints" means any manual or mechanical device, eent attached or adjacent to that the individual cannot h restricts freedom of al access to one's body. include, but are not limited to, restraints, hand mitts, soft ties lchair safety bars. Physical ide practices which meet the aint, such as tucking in a sheet ident confined to bed cannot airs that prevent rising; or n a wheelchair so close to a events the resident from e considered a restraint if they movement. If the bed rail is at the resident in turning or to be out of bed, then the bed rail straint. Wrist bands or devices ger electronic alarms to warn is leaving a room or area do selves, restrict freedom of uld not be considered				
	B. "Chemical re	estraints" means any gic drug that is used for				

Minnesc	ta Department of He	ealth			FURIVIF	PPROVE
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPL	EIED
					С	
		00770	B. WING		12/09	9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
мауо с	LINIC HEALTH SYSTE	- M - I ΔKF CITY	T GRANT ST			
	I		TY, MN 5504			
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TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
2 505	Continued From pa	ige 3	2 505			
	discipline or conver	nience and is not required to				
	treat medical symp					
		means any action taken by the				
		ne purpose of punishing or				
	penalizing a resider					
		ce" means any action taken				
		sident behavior or maintain a				
		er amount of effort that is not				
	in the resident's be					
		measures" means the				
		necessary to alleviate an				
		on or sudden occurrence of a				
	serious and urgent	nature.				
	by: Based on observati review, the facility f (R1) right to be free	ent is not met as evidenced ion, interview, and document ailed to ensure 1 of 3 residents from physical/chemical ff surrounded R1 preventing		Submission of this Allegation of Compliance is not a legal admission deficiency exists or that this Staten deficiencies was correctly cited and	nent of	
		ent, held R1's arms and		not to be construed as an admissio		
		chotic medication without R1's		against the Facility, Administrator,		
		ting any non-pharmacological		Employees, Agents or other individ		
		to the administration of the		who draft or may be discussed in t		
	medication.			Allegation of Compliance. In addition	on,	
				preparation and submission of the		
	Findings include			Allegation of Compliance does not		
				constitute an admission or an agre		
		icident (FRI) submitted to the		of any kind by the Facility of the tru		
		2/6/21, at 1:34 p.m. alleged use		any facts alleged or the correctnes		
		cal restraint. The description of		conclusions set forth in the Statem		
		d, "2 nurses held resident [R1]		the survey agency. Accordingly, the		
		e gave injection through		Facility has prepared and submitte		
		plain to resident injection		Allegation of Compliance solely be		
	taking place."			of the requirements under State ar Federal law that mandate submiss		
	Facility investigative	e summary submitted to the		an Allegation of Compliance within		
		2/10/21, included R1 had		days of receipt of the Statement of		
		y, major depression, dementia		Deficiencies as a condition of parti		
noooto D	epartment of Health	,, ,, ,,	1			

If continuation sheet 4 of 22

#### PRINTED: 06/01/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00770	B. WING		C 12/09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	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 E CROSS-REFERENCED TO THE APPROPRI	
				DEFICIENCY)	
2 505	Continued From pa	ge 4	2 505		
	with behavioral dist	urbance, confusional arousals,		in Title 18 and Title 19 programs. Th	e
		nd agitation. On 12/4/21, R1		submission of this Allegation of	-
		she could not talk to her son,		Compliance within this timeframe sh	ould
		aring began at 6:00 a.m.		in no way be considered or construe	
	Registered nurse (F	RN)-A asked R1 to go back to		an agreement with allegations of	
		morning report, R1 did not		noncompliance or admissions by the	
		t nurse down hallway as he		facility. This plan of correction is not	
		ehavior continued with yelling		construed as an admission by the fa	
		e point a 1:1 was decided by		or any of its agents that the survey a	
		for a period of time with a		findings in this report are true or corr	
		ating with walker towards		The plan of correction is written for the	
		censed practical nurse		purpose of compliance with the rules	S OT
	. ,	R1 into the activity room so		participation for the Medicaid and	
		fast. No behavior outburst ast. After R1 was done eating,		Medicare programs.	
		into the dining room, R1 was		R1, care plan reviewed and revised.	
		g about not talking with her		Education provided to nursing staff of	n
		ted R1 to her room for		12/7/2021 regarding documentation	
		ed but was yelling and		electronic behavior note , and policie	
		s time. Other residents on the		which included Vulnerable Adult and	
		/ing concerns for their safety		Restraint which included physical an	
		btained an order for Haldol		chemical restraint. 12/21/2021 behavior	
		amuscular (IM) and send to		education regarding documentation	
		ER). As R1 came out of the		behavior note template.	
		PN-A took hold of R1's arms		Education continues to be provided t	to all
	while LPN-B admin	istered the IM Haldol through		staff regarding restraints policy and	
	R1's clothing. After	the injection R1 began		Vulnerable adult policy.	
		r striking LPN-A and RN-A.		Lake City Care Center to monitor its	
		d staff had informed R1 her		corrective actions by conducting wee	
		to see R1, R1 calmly walked to		psychotropic interdisciplinary meetin	g with
	the ER with staff.			review of identified residents which	
				includes ensuring consents, non-pha	
		num Data Set (MDS) dated		medications, effectiveness, behavior	al
		R1's brief interview for mental		documentation, prn and scheduled	c
		2, which indicated moderate		psychotropic medications. Findings	
		nt. The MDS indicated R1 did		the meeting will be reported at the Q	
		of delirium and did not have		meeting for evaluation and feedback	
		ehaviors. The MDS identified		Deficiency to be corrected on Janual	ry
		staff assistance for bed		11th, 2022.	
	epartment of Health	nd locomotion on and off the		Director of Nursing responsible to er	ISUIC

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(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 505	Continued From pa	nge 5	2 505			
		n indicated R1 was epressant and antipsychotic luring the assessment period.		compliance.		
	STAT doses of Ser	ers on 12/4/21, included the oquel and Haldol, physician de orders for physically he administration.				
	individualized beha plan did not include use intimidation and antipsychotic medic to give medications consent prior to add included, "[R1] may times when she be utilize physicians' of for follow up." and ' violent and un-redir security or the local her to the ER for ex	ed 11/11/21, identified vioral interventions; the care e, identify, or instruct staff to d/or restraints to administer cation, and did not direct staff s without first obtaining R1's ministering. The care plan y refuse her medications at comes agitated. Staff are to rders or call on call provider 'If [R1] becomes physically rectable, staff are to call I police department to assist yaluation. Charge nurse to ine when necessary."				
	7:00 a.m. R1 was a staff wanting to talk the on-call physicia behavior continued increase Seroquel a note included, "Res dose." The note includely that she wan started to yell at res hallways. In additio	dated 12/4/21, indicated at agitated, yelling/screaming at to her son. The nurse called in at 7:15 a.m. when the ; physician gave order to and add as needed dose. The sident did take increased dicated R1 continued to yell ited to see her son, and R1 sidents as R1 walked down n, R1 threatened staff by and pushed staff with her hysician] was called and				

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2 505	Continued From pa	ge 6	2 505			
	able to give injectio	n."				
	a.m. the administra nursing (IDON) wer submitted FRI. The into work the morni for a report for stan had transferred to t looked for more spe progress note that i administer an IM inj started investigating interviewed and fou knew it was a vulne a report to the State possible. IDON stat 12/4/21, and stated specific information sequence of events investigation she has started at 6:15 a.m. for an extra dose of LPN-A administered consent and withou interventions, R1's and became increa IM Haldol order, an surrounded her by the RN-B injected the H through her clothing two nurses held R1 time in which Haldo clear and the time t	nference on 12/8/21, at 10:23 tor and interim director of re interviewed regarding the IDON stated she had come ng of 12/6/21, and was looking d-up meeting and saw that R1 he hospital. IDON stated she ecific information and found a t took four nurses to jection. IDON stated she g immediately and once she ind out what happened, she erable adult incident and made e Agency as quickly as ted the incident happed on the progress notes lacked about the timing of the s. IDON indicated so far in her ad found, R1's behaviors ., RN-A had obtained an order f Seroquel around 7:15 a.m., d the medication without R1's t attempt of care plan behaviors of yelling continued singly agitated, RN-A obtained d while 3 other nurses the entrance of her room, faldol into R1's buttock g without R1's knowledge and 's arms. IDON indicated the of was administered was not hat R1 transferred to the entified in the record. IDON				

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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		
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2 505	Continued From page 7 not enough to give a Haldol injection. Honestly there was no redirection, she was cursing and yelling, she [R1] didn't start hitting until after injection was given." IDON indicated the three nurses involved reported they had not recognized that using physical restraints was not in accordance with the standards of practice and against facility policy because that was not the standard that was set by the previous DON. IDON stated the facility does not endorse or use physical restraints and if staff thought R1 was in jeopardy of harming herself and others they should have called 911 for assistance. IDON stated the Seroquel and IM Haldol should not have been administered without R1's consent and a means to attempt to control R1's behaviors, instead care plan interventions should have been offered and attempted first.		ł			
	LPN-A stated arour informed R1 require because she was h R1 was very agitate about wanting to ca walked down hallwa could not allow R1 f plan. LPN-A indicate R1 down by telling I phone number, how indicated R1's yellir upset and scare oth R1 walked around y distance to make so verbally assault res R1 went to her roor RN-B] walked dowr	on 12/8/21, at 11:30 a.m. ad 7:00 a.m. he had been ed direct supervision (1:1) aving behaviors. LPN-A stated ed, she woke up mad, angry all her son, yelling as she ays. LPN-A stated the staff to talk to her son per R1's care ed he had attempted to calm her he would look for the vever, this did not work. LPN-A ng behaviors were starting to her residents. LPN-A stated as yelling, he followed from a ure R1 did not physically or idents. LPN-A indicated when n, they [RN-A, LPN-B, and n to R1's room, as R1 walked 'N-A indicated staff had				

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2 505	R1's left side, and L indicated R1 had be aggressive manner thought was standin indicated at some p R1's arm to preven sure if the hold hap administered the m all happened so fas injection was given however, staff were adjacent emergence while R1 was surro interventions for be not offered or attem unawareness and o R1 and preventing the injection was a indicated he did not was a manual phys standing up and no stated a similar pra R1 when the previo year ago) and thoug acceptable until 12/ and provided re-edu	At side, thought RN-A was on PN-B was behind R1. LPN-A been pushing her walker in an towards RN-B who he and in front of R1. LPN-A booint he physically grabbed t movements and was not pened before or after LPN-B edication for sure because it st. LPN-A indicated after the R1 continued to yell/scream, able to escort R1 to the y department. LPN-A indicated unded by staff, R1's care plan havioral management were apted. LPN-A indicated an lid not identify that surrounding her from walking away to give type of restraint. LPN-A t think holding onto R1's arms ical restraint because R1 was t lying down in bed. LPN-A ctice had been used before on us DON was there (about a ght the practices were 6/21, when he was informed ucation by the IDON.	3			
	facility at 6:30 a.m. walking around her and screaming abo son, R1 was scarin providing 1:1 to ma safe from R1. LPN- were directed toward	2/4/21, she had arrived at the LPN-B indicated R1 was unit and the other unit yelling ut not being able to call her g other residents. LPN-A was ke sure other residents were A thought R1's behaviors rd staff and did not observe R1 erbally abusing other residents				
linnoasta D	were directed towar physically and/or ve LPN-B stated RN-A					

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2 505	<ul> <li>REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>Continued From page 9</li> <li>stated she drew the medication up and volunteered to give it which made her nervous and scared. LPN-B stated R1 had gone into her room, and they (RN-A, LPN-A, and RN-B) were trying to get R1 to go back into her room, which made R1 get even madder. LPN-B indicated RN-A was on R1's right side and LPN-A was on her left side, RN-A was in front. LPN-B stated RN-A directed her to come around the doorway and give R1 the injection. LPN-B indicated she gave R1 the injection. LPN-B indicated she gave R1 the injection in her left buttock through her pants. LPN-B stated she did not ask or inform R1 of the injection first and stated R1 tried to turn around with her walker. LPN-B stated an awareness that RN-A and LPN-A held onto R1 but was not able to articulate how or at what point LPN-A and RN-A had restrained R1's arms. LPN-B indicated at the time she did not identify wrong doing by surrounding R1, physically restraining R1's arms, and injecting medication through R1's pants because that had been the previous practice. LPN-A stated she was not aware until Monday 12/6/21, when administration had provided education and informed her of the policy.</li> </ul>					
	stated she was the 12/4/21. RN-A state yelling and screami assaulted a nurse a 6:30 a.m. RN-A ind continued, RN-A ind assaulted and/or ha was disruptive and	on 12/8/21, at 1:47 p.m. RN-A charge nurse working on ed R1 got up angry and was ng. RN-A stated R1 verbally as they left the building around icated R1's behaviors dicated R1 had not physically armed other residents but, R1 scaring other residents as she unit and the other unit. RN-A				
	indicated around 7: Seroquel without R no effect, she called	15 she had administered the 1 knowing, it seemed to have d the physician a second time r IM Haldol. RN-A indicated R1				

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2 505	Continued From pa	ige 10	2 505			
	R1 started exiting h went behind R1 and startled R1. R1 pick back toward LPN-B arms around R1's a striking out. RN-A s 15 to 30 seconds. F yell/scream at staff however, R1 was a adjacent emergence that her son was wa indicated an unawa policies pertaining t and manual holds b	to use the bathroom, and as her room, that is when LPN-B d gave R1 the injection, which ked up her walker and turned B. RN-A and LPN-B laced their arms preventing her from stated they held R1's arms for RN-A stated R1 continued to for about 20-30 minutes, greeable to walk to the ey room after staff informed R1 aiting for her there. RN-A areness of the facility's restraint to medication administration because it had been an e of the previous DON. RN-A eived re-education on 12/6/21.				
	at 4:30 p.m. R1 sat stated things were fall the other day wi mention her son an behaviors. R1 stood her walker, and wa unidentified nurse, R1, explained she did not have shoes	ion and interview on 12/8/21, in a chair in her room. R1 going fine except she had a hile at the hospital, did not id/or of verbal/physical d up with socks on, grabbed lked out into the hallway. An walked down the hallway to was concerned because R1 on and did not want her to fall. I the nurse to escort her back				
	RN-B stated on 12/ 6:00 a.m. and was behaviors had start R1's unit. RN-B ind had walked over to and saw/heard R1 R1 was walking ard	on 12/8/21, at 6:37 p.m. 4/21, she had started work at not sure what time R1's yelling ed because she was not on dicated around 7:30 a.m. R1 the unit she was working on yelling at LPN-A. RN-B stated bund the nursing units yelling taff about wanting to talk to				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
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2 505	Continued From pa	age 11	2 505			
	staff had provided residents were not around 8:30 a.m. R and RN-A had obta RN-B stated when LPN-B with the Hal down the hallway b following her from a when R1 was exitin standing around he in her room, and R then asked R1 why and R1 got in her fa thought she was go when LPN-B must R1 turned and look she had given her a and RN-A had grab from striking out or		r 5			
	dated 4/2018 includ facility to ensure a r shortest duration po and review of device	raint-Physical Device, Use of ded, It is the policy of the restraint is utilized for the ossible, resident is comfortable ces on admission, quarterly,	е			
	therapeutic is being NOTE: RESTRAIN BE USED AS PUNI SUBSTITUTE FOR	ge in status, and when a considered and trialed. TS OF ANY TYPE WILL NOT ISHMENT OR AS A MORE EFFECTIVE RSING CARE OR FOR THE				
	CONVENIENCE O procedure directed	F FACILITY STAFF. The the following: 1) if the device				
	the least restrictive	essary, the goal will be to use type of device for the shortest sible. 3) A physician's order for	t			
		estraint is required and must				

Minnes	ota Department of He	alth			FORM	APPROVED
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2 505	Continued From pa	ge 12	2 505			
	(medical symptom)	and duration of application.				
21525	The director of nurse could review or revi of physical/chemica designee could pro regarding physical of Assessment and As could do random at TIME PERIOD FOR (21) days	HOD FOR CORRECTION: sing (DON) and/or designee ise policies regarding the use al restraints. The DON and /or vide education for staff restraint use. The Quality ssurance (QAA) committee udits to ensure compliance. R CORRECTION: Twenty one	21535			1/11/22
	Drug Usage; General Subpart 1. General must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without aded D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finand	ral al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug				

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STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i:	COMP	LETED
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21535	Continued From pa	ige 13	21535			
		te Law Library. It is not				
	by: Based on observative review, the facility f and evaluate the ef non-pharmacologic interventions for tar identified for antips residents (R2, R3) management. Findings include R2's quarterly Minir indicated R2 had m did not have signs/s rejection of care be R2 was administered	al behavioral management rget behaviors that were ychotic medications for 2 of 3 reviewed for behavioral mum Data Set dated 11/10/21, noderate cognitive impairment, symptoms of delirium, and had haviors. The MDS identified ed antipsychotic and dications during the		Submission of this Allegation of Compliance is not a legal admis deficiency exists or that this Sta deficiencies was correctly cited not to be construed as an admis against the Facility, Administrate Employees, Agents or other indi who draft or may be discussed i Allegation of Compliance. In ado preparation and submission of t Allegation of Compliance does r constitute an admission or an ag of any kind by the Facility of the any facts alleged or the correct conclusions set forth in the State the survey agency. Accordingly, Facility has prepared and submit Allegation of Compliance solely of the requirements under State	tement of and is also solon or, of any viduals n the dition, ne dition, ne dition, ne dition, ne dition, ne dition, ne dition, ne dition, ne dition, ne dition, ne dition, ne dition, truth of ess of any ement by the tted this because	
	diagnoses of major dementia with beha anxiety disorder. R used psychotropic i aforementioned dia target behaviors; T sleeplessness Cym pain Seroquel 4. ho others 6. delirious s care plan directed s non-pharmacologic mood/behavior plan monitor, and evalua	ignosis and identified R2's arget behaviors: Trazodone 1. abalta 2. drinking poorly 3. c/o ollering out 5. hitting out at statements. The psychotropic		of the requirements under State Federal law that mandate subm an Allegation of Compliance with days of receipt of the Statement Deficiencies as a condition of pa- in Title 18 and Title 19 programs submission of this Allegation of Compliance within this timefram in no way be considered or cons an agreement with allegations o noncompliance or admissions b facility. This plan of correction is construed as an admission by th or any of its agents that the surv findings in this report are true or The plan of correction is written	ission of of articipation 5. The e should strued as f y the not to be ne facility ey agents correct.	

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21535	Continued From pa	ige 14	21535				
	a "mood and behavidentify non-pharma R2's target behavio R2 had delirium or which the care plan provide gentle reali Reorient to person, required. R2's depr staff to administer r encourage activities in. R2's physician order identified R2's curre included: -Seroquel (antipsyc milligrams (mg) twi behavioral disturba -Buspirone (anxioly times a day for anx -Duloxetine (antide two times a day for -Trazodone (antide one time a day for i R2's physician order	vior" focus and did not clearly acological interventions for ors. R2's care plan indicated acute confusional episodes in a directed staff to redirect and ty orientation as required. , place, time, situation as ression plan of care directed medications as ordered and s that R2 enjoyed participating er report dated 12/10/21, ent medications which chotic medication) 12.5 ce per day for dementia with nce. tic medication) 30 mg two iety. pressant medication) 30 mg anxiety. pressant medication) 25 mg insomnia/depression. ers also identified target rt codes for staff to		purpose of compliance with the participation for the Medicaid a Medicare programs. R2 care plan updated to include behavior, non-pharmacological interventions for target behavior R3 Care plan and medical recorreviewed and updated to reflect medication consistent with phy orders and target behaviors. EHR list of residents receiving psychotropic medication ensu- etar includes behaviors, non -pharmacological intervention Review of resident behavioral communication between shift Education to continue with add staff VA education. Additional "psychopharmacologic drug us At least quarterly comprehens psychotropic assessments of neceiving psychotropic medication corrective actions by conductin "psychotropic interdisciplinary with review of identified reside	and de mood and al ors, triggers. ord ct care plan /sician re resident s. to shift. ditional all policy se." ive residents tions. itor its ng weekly "meeting nts which		
		for associated psychotropic		includes ensuring consents, ne medications, effectiveness, be documentation, prn and sched	on-pharm havioral		
	"Nursing to chart or behaviors qshif [eve examples of agitation be harmful to reside that cause interfere	e dated 11/16/21 included, n patient's mood and ery shift], with specific on, or any behaviors that may ent, staff or other residents, or ence in caring for the patient. . [nurse practitioner/physician <s."< td=""><td></td><td>psychotropic medications. Fin the meeting will be reported at meeting for evaluation and fee Random audits to include POO documentation, behavioral mo interventions report, behaviora note up to 3x a week x 3 mont from audits will be reported at</td><td>idings from the QAPI edback. C behavioral phitoring and al nurses ths. Finding the monthly</td><td></td></s."<>		psychotropic medications. Fin the meeting will be reported at meeting for evaluation and fee Random audits to include POO documentation, behavioral mo interventions report, behaviora note up to 3x a week x 3 mont from audits will be reported at	idings from the QAPI edback. C behavioral phitoring and al nurses ths. Finding the monthly		
	R2's behavioral rec	ord was reviewed between		QAPI meeting for additional fe evaluation.	edback and		

## PRINTED: 06/01/2022 FORM APPROVED

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		PLETED	
		00770	B. WING			C / <b>09/2021</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
MAYO C	LINIC HEALTH SYSTE	-M - I AKE 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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
21535	Continued From pa	ge 15	21535				
	11/19/21 to 12/9/21 documentation of R lacked evidence no interventions were of offered and when in documented, the re effectiveness. Exan included: -Progress note date "Resident is unhap go home. Refused drink any ensure [d only water. -Progress note date observed anxiousne in w/c [wheelchair] f -Progress note date included, "This resid and hitting out when Staff have attempted continued to yell at changed required a -Progress note date included, R2 was " anxious." -Progress note date included, "This resid staff assist and has vitals this shift." -Progress note date included, "Resident shift." -Progress note date included, "Resident staff assist and has vitals this shift."	although the record reflected 2's behaviors, the record an-pharmacological consistently attempted or neterventions were ecord lacked evaluation of mples from R2's record ed 11/19/21, included, py with staying here, wants to to eat dinner and refused to ietary nutritional supplement], ed 11/21/21, included, "No ess. Resident withdrawn. Up for a short time." ed 11/23/21, at 3:20 a.m. dent has been very resistive in staff attempt to help her. ed to redirect but she staff attempt to hit staff. Being issist of 2 this shift." ed 11/23/21 at 1:41 p.m. refused to eat lunch this ed 11/23/21, at 2:42 a.m. dent has been very resistive to a refused to let staff check her ed 11/24/21, at 2:31 p.m. t has been refusing to let staff ed 11/26/21, at 3:22 a.m. t hit staff during noc [night]	t	Deficiency to be corrected 11th, 2022 Director of nursing respon- compliance.			

Minnesota Department of Health STATE FORM

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If continuation sheet 16 of 22

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00770	B. WING			09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	LINIC HEALTH SYSTE	EM - LAKE CITY	ST GRANT STF TY, 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From pa	ige 16	21535			
	when assisting with	brief change."				
	documentation) wa 12/9/21, the docum behavior by a nume documentation lack non-pharmacologic offered when there The record also ide Examples included -On 12/1/21, POC of identified R2 had bo kicking/hitting and p -On 12/2/21, boxes were blank. -On 12/3/21, boxes were blank. -On 12/4/21, boxes were blank. -On 12/5/21, boxes -On 12/6/21, boxes -On 12/7/21, box for -On 12/8/21, POC of identified R2 had bo pinching/scratching	al interventions attempted or was charting of a behavior. entified multiple blank boxes. : documentation for night shift ehaviors of rejection of care, binching/scratching/spitting. for day/evening/night shift for day and evening shift of for day and evening shift for all shifts were blank. for all shifts were blank. or night shift was blank. documentation for night shift ehaviors of kicking/hitting and				
	assessment and eve effectiveness of no interventions in com psychotropic medic lowest therapeutic medications.	valuation of R2's behaviors and n-pharmacological behavioral nbination with effectiveness of cations to ensure necessity or dose of psychotropic				
	documentation and identify non-pharma	N)-B reviewed R2's behavioral confirmed the record did not acological interventions offered stated the behaviors were no	Ł			

	ota Department of He	ealth (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
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		500 WES	T GRANT STR			
MAYO C	LINIC HEALTH SYSTE	EM - LAKE CITY LAKE CI	TY, MN 55041			
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				DEFICIENC	(Y)	
21535	Continued From pa	ige 17	21535			
	very descriptive and	d should be, interventions				
		be documented in a progress				
	note and if those in	terventions worked or not.				
	During an observat	ion on 12/9/21, at 12:22 p.m.				
	R2 sat at the dining	room table in her wheelchair,				
	R2 did not display a	any behaviors.				
	During an interview	on 12/9/21, at 12:25 interim				
		(IDON) indicated the facility				
	currently did not ha					
		mmittee that reviewed behaviors, however, indicated				
		with a pharmacist. IDON stated				
	they encourage the	least amount of psychotropic				
		ON indicated an expectation				
		the resident and evaluate for hat is causing the behavior.				
		s should be documenting				
	interventions that w	vere utilized so it could be				
	determined if the in	terventions were working.				
		dated 11/24/21, indicated R3				
		e impairment with no				
		delirium, did not have Iusions and did not have				
	behaviors. The MD					
		sychotic and antidepressant				
	medications during	the assessment period.				
	R3's care plan date	ed 11/30/21, indicated R3 had				
		depressive disorder, anxiety				
		entia with behavioral				
		nood and behavior care plan				
		story of depression and receive medication for these				
		are plan identified R3's target				
	behaviors for psych	notropic medications which				
	included, Target be	haviors to observe for				

M - LAKE CITY 500 WES LAKE CI EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	B. WING DDRESS, CITY, ST TT GRANT STR TY, MN 55041 ID PREFIX TAG	PROVIDER'S PLAN OF CORF	12/0	C )9/2021
M - LAKE CITY 500 WES LAKE CI EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	T GRANT STR TY, MN 55041 ID PREFIX	PROVIDER'S PLAN OF CORF	PECTION	
M - LAKE CITY EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORF		
MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX			
- 40		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
ant medication) 100 mg once on. c medication) 20 mg twice s also identified target codes for staff to or associated antipsychotic tions associated with target sistent with the physician re inconsistent with care plan target behaviors. The a start date of 7/19/21, des for target behaviors to des for target behaviors to des for target behaviors to des for target behaviors to des for target behaviors to des for target beh				
	<ul> <li>G) Isolating self. Buspirone: alizations of anxiety inges in cognition K) None. vior plan of care included harmacological interventions arget behaviors. The care monitor/document side ness of medication</li> <li>s dated 12/9/21, was medications that were plan. Medication orders</li> <li>otic medication) 12.5</li> <li>e morning and 25 mg at a with behavioral disturbance int medication) 100 mg once on.</li> <li>c medication) 20 mg twice</li> <li>s also identified target codes for staff to r associated antipsychotic tions associated with target istent with the physician re inconsistent with care plan target behaviors. The a start date of 7/19/21, des for target behaviors to l: 1) hallucinations 2) yelling mg Buspar 5) restlessness r) anxious behavior 8) sexual towards others 0) no</li> </ul>	<ul> <li>S) Isolating self. Buspirone: alizations of anxiety inges in cognition K) None. vior plan of care included harmacological interventions arget behaviors. The care monitor/document side hess of medication</li> <li>is dated 12/9/21, was medications that were plan. Medication orders</li> <li>otic medication) 12.5</li> <li>e morning and 25 mg at a with behavioral disturbance. Int medication) 100 mg once on.</li> <li>c medication) 20 mg twice</li> <li>is also identified target codes for staff to r associated antipsychotic tions associated with target istent with the physician re inconsistent with care plan target behaviors. The a start date of 7/19/21, des for target behaviors to l: 1) hallucinations 2) yelling mg Buspar 5) restlessness ') anxious behavior 8) sexual towards others 0) no</li> </ul>	<ul> <li>S) Isolating self. Buspirone: alizations of anxiety inges in cognition K) None. vior plan of care included harmacological interventions arget behaviors. The care monitor/document side ness of medication</li> <li>s dated 12/9/21, was medications that were plan. Medication orders</li> <li>otic medication) 12.5</li> <li>e morning and 25 mg at a with behavioral disturbance. nt medication) 100 mg once on.</li> <li>c medication) 20 mg twice</li> <li>s also identified target codes for staff to r associated with target istent with the physician re inconsistent with care plan target behaviors. The a start date of 7/19/21, des for target behaviors to 1: 1) hallucinations 2) yelling ng Buspar 5) restlessness ') anxious behavior 8) sexual towards others 0) no</li> </ul>	<ul> <li>alizations of anxiety</li> <li>inges in cognition K) None.</li> <li>vior plan of care included</li> <li>narmacological interventions</li> <li>arget behaviors. The care</li> <li>monitor/document side</li> <li>ness of medication</li> <li>s dated 12/9/21, was</li> <li>medications that were</li> <li>plan. Medication orders</li> <li>otic medication) 12.5</li> <li>e morning and 25 mg at</li> <li>a with behavioral disturbance.</li> <li>nt medication) 20 mg twice</li> <li>s also identified target</li> <li>codes for staff to</li> <li>r associated antipsychotic</li> <li>tions associated with target</li> <li>istent with the physician</li> <li>re inconsistent with care plan</li> <li>target behaviors to</li> <li>b) anxious behavior 8) sexual</li> <li>towards others 0) no</li> </ul>

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00770	B. WING			C 09/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	INIC HEALTH SYST	FM - LAKE CITY	ST GRANT STR TY, MN 55041			
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21535	Continued From pa	age 19	21535			
	lacked evidence th interventions were offered and when i documented, the re effectiveness. Exai included: -Progress note dat included, "Residen another resident im [sic] resident threa throat. Resident threa taken back to the u nurse updated." R3's Point of Care documentation) wa to 12/9/21, the doc behavior by a num documentation lac non-pharmacologic offered when there The record also ide Examples included -On 11/28/21, POC identified R3 had b and pushing. -On 12/6/21, POC shift identified R3 h yelling/screaming. R3's progress note	ecord lacked evaluation of mples from R3's record ed 12/3/21, at 10:30 p.m. t became agitated toward the dining room. Per "RNA tened to cut the resident's ad no sharp objects within esident was yelling out loudly nt agitation. Resident was unit for supper meal. Charge (POC-nursing assistant as reviewed between 11/28/21 umentation only identified a erical code in a box. POC ked evidence of cal interventions attempted or e was charting of a behavior. entified multiple blank boxes. Cocumentation for day shift ehaviors of yelling/screaming documentation for night shift ehaviors of pushing. documentation for evening nad behaviors of solution for evening had behaviors of pushing. documentation for evening had behaviors of solution for evening had behaviors of the behaviors of pushing. documentation for evening had behaviors of has fully a statempted or evening had behaviors of has behaviors of has behaviors of has behaviors of has behaviors of has behaviors of				
	address or further	define the behaviors that were C on 11/28/21, 12/6/21, and				

TATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:			
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	LINIC HEALTH SYST	FM - LAKE CITY	ST GRANT STR			
		LAKE CI	TY, MN 55041			
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21535	Continued From pa	age 20	21535			
	12/7/21.					
	assessment and e effectiveness of no interventions in co psychotropic medic	I evidence of a comprehensive valuation of R3's behaviors and on-pharmacological behavioral mbination with effectiveness of cations to ensure necessity or dose of psychotropic	b			
	RN-B reviewed R3 and confirmed the non-pharmacologic attempted. RN-B s very descriptive an were supposed to	v on 12/9/21, at 12:14 p.m. Vs behavioral documentation record did not identify cal interventions offered or stated the behaviors were not ad should be, interventions be documented in a progress interventions worked or not.				
		tion on 12/9/21, at 12:22 p.m. g room table in her wheelchair, any behaviors.				
	indicated the facilit psychotropic interd reviewed medicatio indicated the facilit DON stated they e psychotropic medic expectation that nu evaluate for the roo behavior. IDON stated documenting interv	v on 12/9/21, at 12:25 IDON, cy currently did not have a disciplinary committee that ons and/or behaviors, however cy worked with a pharmacist. Incourage the least amount of cation use. IDON indicated an ursing assess the resident and ot cause of what is causing the ated nurses should be ventions that were utilized so it ed if the interventions were				
		THOD OF CORRECTION: sing (DON) or designee could				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
	00770	B. WING			C 09/2021
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ige 21	21535			
medications, educa	te staff, and perform audits to				
TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
	OF CORRECTION PROVIDER OR SUPPLIER LINIC HEALTH SYSTE (EACH DEFICIENC' REGULATORY OR L Continued From pa review policies/proo medications, educa ensure compliance TIME PERIOD FOI	OF CORRECTION       IDENTIFICATION NUMBER:         00770       00770         PROVIDER OR SUPPLIER       STREET A         LINIC HEALTH SYSTEM - LAKE CITY       500 WES         SUMMARY STATEMENT OF DEFICIENCIES       LAKE CI         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 21         review policies/procedures for unnecessary medications, educate staff, and perform audits to ensure compliance.       TIME PERIOD FOR CORRECTION: Twenty One	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00770       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, S'         LINIC HEALTH SYSTEM - LAKE CITY       500 WEST GRANT STELAKE CITY, MN 55041         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 21 review policies/procedures for unnecessary medications, educate staff, and perform audits to ensure compliance.       21535         TIME PERIOD FOR CORRECTION: Twenty One       ID	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00770       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       500 WEST GRANT STREET         LINIC HEALTH SYSTEM - LAKE CITY       SUMMARY STATEMENT OF DEFICIENCIES         SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         Continued From page 21       21535         review policies/procedures for unnecessary       21535         TIME PERIOD FOR CORRECTION: Twenty One       ID	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING: