



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 30, 2026

Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

RE: CCN: 245218

Cycle Start Date: July 31, 2026

Dear Administrator:

On September 4, 2026, we notified you a remedy was imposed. On September 29, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 22, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 31, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 4, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 31, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 22, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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September 30, 2026

Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

Re: Reinspection Results
Event ID: 2D0172-H2

Dear Administrator:

On September 17, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 31, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

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August 19, 2026

Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

RE: CCN: 245218

Cycle Start Date: July 31, 2026

Dear Administrator:

On July 31, 2026, a survey was completed at your facility by the Minnesota Department of Health 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:

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response

Health Regulation Division

Minnesota Department of Health

Rochester District Office

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: Lisa.Krebs@state.mn.us

Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by **October 31, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **January 31, 2027** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is fluid and cursive, with the first letter of the last name being a large, stylized 'Z'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us



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August 19, 2026

Administrator
MAYO CLINIC HEALTH SYSTEM - LAKE CITY
500 WEST GRANT STREET
LAKE CITY, MN 55041

Re: State Nursing Home Licensing Orders

Event ID: 2D0172-H1

Dear Administrator:

The above facility survey was completed on July 31, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules 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 only a suggestion, and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/30/26 and 7/31/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52183552C (3119464) with a deficiency issued at F684, F842, and F775. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			09/09/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess a significant weight increase and implement care-planned monitoring for edema and signs and			F0684	Corrective Action: R4's care plan was updated to ensure monitoring for edema and signs/symptoms of congestive heart failure. R4 was assessed by provider for fluid volume. Corrective Action as it applies to other residents: Audits of residents at risk for congestive heart failure or fluid overload were completed to ensure appropriate care plan interventions. Residents with a diagnosis of congestive heart failure (CHF) or those at risk for fluid overload had their care plans updated to include monitoring, documentation and reporting of signs and symptoms associated with CHF or fluid overload. These residents were comprehensively assessed. Monitoring was added daily for residents with		09/09/2026

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

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

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F0684 SS = D	Continued from page 1 symptoms of congestive heart failure for 1 of 3 residents (R4) reviewed for change in condition. Findings include Findings include: R4's face sheet identified diagnoses of heart failure and diabetes. R4's quarterly Minimum Data Set (MDS) dated 6/5/26, identified R4 had moderate cognitive impairment, no behaviors, no rejection of cares, needed partial/moderate assistance for transfers, and did not take a diuretic (water pill). R4's care plan dated 11/20/25, identified R4 had a diagnosis of congestive heart failure. Goal to have clear lung sounds, heart rate and rhythm within normal limits. Corresponding interventions as follows: -Give cardiac medications as ordered (dated 11/6/25). -Monitor/document/report as needed any signs and symptoms of congestive heart failure such as dependent edema of legs and feet, shortness of breath on exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles/wheezes in the lungs. Report to the provider as indicated (dated 11/6/25). -Weight as ordered (dated 1/8/26). R4's physician progress note dated 6/2/26, identified R4 had a diagnosis of chronic congestive heart failure and a coronary stent status post. No changes in treatment and continue to monitor. Review of R4's vital sign record from 5/2/26 through 7/24/26 identified the following weights: 6/5/26: 165.6 lbs. 6/12/26: 165.6 lbs. 6/26/26: 164.7 lbs. 7/3/26: 172.6 lbs. 7/24/26: 173.6 lbs. R4's weight increased from 164.7 pounds on 6/26/26 to 172.6 pounds on 7/3/26, an increase of 7.9 pounds. Review of R4's record, including the			F0684	Continued from page 1 congestive heart failure or those at risk for fluid overload. Documentation and reporting signs and symptoms associated with CHF or fluid overload are reported to provider. Daily weights for residents with heart failure. Update provider for 3 pound or greater weight gain in 24 hours or 5-pound weight gain in one week unless otherwise ordered. The Change of Condition policy was reviewed and remains current. Nursing staff will be re-educated regarding the Change of Condition policy. Reoccurrence will be prevented by: Audits will be conducted three times a week for 2 months to ensure residents are appropriately assessed for signs and symptoms of congestive heart failure or fluid overload. This includes observation to ensure accuracy of documentation. Results of the audits will be brought to QAPI for review and further recommendation. Date of Completion: 9/9/2026 The correction will be monitored by: Director of Nursing or designee.		09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0684 SS = D	Continued from page 2 June and July Treatment Administration Records (TARs), did not identify completed edema or congestive heart failure monitoring and no indication comprehensive assessments of the weight increase were completed. R4’s progress note dated 7/6/26 at 6:22 a.m., identified R4 had concerns about her lungs filling up with fluid again and requested to see a doctor. R4 has had an almost 10-pound weight gain within the past week and is short of breath. R4’s nurse practitioner note dated 7/6/26, identified R4 had been seen for evaluation of shortness of breath and a ten-pound weight gain and concern for fluid retention. New orders for chest radiograph (Xray) to evaluate pulmonary fluid retention and laboratory studies. R4’s nurse practitioner note dated 7/8/26, identified results are stable and will continue to monitor. During an interview on 7/31/26 at 1:04 p.m., R4 stated she had a diagnosis of heart failure, however, does not take a “water pill” for it. R4 explained a few weeks prior she became short of breath and felt like she was filling up with fluid and had asked to see the doctor. R4 was worried she was having problems with her heart failure, explained staff needed to watch her closely to make sure “I do not get worse and must be sent to the hospital. “ During an interview on 7/31/26 at 12:47 p.m., nurse manager registered nurse (RN)-B stated R4 had diagnosis of congestive heart failure, however, her record did not have any monitoring for edema or worsening CHF symptoms. RN-B explained that a resident with a diagnosis of CHF needed to be watched closely to ensure they were not having an exacerbation of CHF and without daily monitoring that could be missed. During an interview on 7/31/26 at 1:13 p.m., RN-A stated residents with a diagnosis should be watched closely to assess for changes like shortness of breath, lung sounds, weight gain and edema, however, R4 has not been monitored for any of these on a daily basis and should be. RN-A explained by monitoring a resident with CHF closely will allow small changes to be caught quickly and get treatment for it. Review of the facility’s policy of Change of Condition Assessments dated 4/16/25, identified the purpose of the policy is to ensure timely detection, documentation, and intervention for any significant			F0684			09/09/2026

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F0684 SS = D	Continued from page 3 alteration in a patient’s baseline status, thereby safeguarding patient health and wellbeing. A focus assessment (a targeted approach to assessing a patient for a specific health concern or area of care. Used to evaluate the patient's immediate needs, symptoms, or risk factors related to a particular condition, system, or issue. Requested a policy on CHF but did not receive.			F0684			09/09/2026
F0775 SS = D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure laboratory reports were filed in the clinical record for 1 of 1 resident (R4) reviewed for edema monitoring. Findings include: R4’s face sheet identified diagnoses of heart failure and diabetes. R4’s quarterly Minimum Data Set (MDS) dated 6/5/26, identified R4 had moderate cognitive impairment, no behaviors, no rejection of cares, and needed partial/moderate assistance for transfer. R4’s progress note dated 7/6/26 at 6:22 a.m., identified R4 had concerns about her lungs filling up with fluid again and requested to see a doctor. R4’s nurse practitioner note dated 7/6/26, identified R4 had been seen for evaluation of shortness of breath. New orders for chest radiograph (Xray) to evaluate for pulmonary fluid retention and laboratory studies. Review of R4's electronic health record (EHR) from 7/6/26 through 7/31/26, did not identify any laboratory or chest imaging results. During an interview on 7/31/26 at 12:47 p.m., registered nurse (RN)-B stated R4 had a chest x-ray completed on 7/7/26 and laboratory testing completed on 7/8/26; however, R4’s EHR did not contain the test results or documentation of the			F0775	Corrective Action: R4’s laboratory reports for the past three months have been reviewed and filed in their clinical record. Corrective Action as it applies to other residents: Residents laboratory results for the past three months have been reviewed and filed in their clinical record. Medical Records or Health Unit Coordinators will ensure laboratory results are reviewed and uploaded into the resident's health record after each encounter. The Documentation Standards policy was reviewed and remains current. Staff will be re-educated regarding the Documentation Standards policy. Reoccurrence will be prevented by: Audits two times a week for 2 months to ensure laboratory results are in resident's clinical record. Results of the audits will be brought to QAPI for review and further recommendation. Date of Completion: 9/9/2026 The correction will be monitored by: Director of Nursing or designee.		09/09/2026

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F0775 SS = D	Continued from page 4 provider's response to the results. RN-B explained the facility did not routinely place laboratory results in the resident's medical record because the results were available in the outside facility's EHR. Staff would access the outside facility's EHR when they needed to review the results. RN-B further explained it was the responsibility of the outside clinic to ensure the facility received the results and not the facility's responsibility to obtain them. During an interview on 7/31/26 at 1:13 p.m., regional registered nurse (R-RN) stated the facility should be ensuring all laboratory results are followed up on to ensure a response from the ordering provider and a copy of the laboratory results placed in the resident's EHR. Requested the facility's policy on laboratory results but did not receive.			F0775			09/09/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the			F0842	Corrective Action: R1 was discharged to the hospital. R4's missing provider notes from July were obtained and reviewed and put in electronic health record. Corrective Action as it applies to other residents: Clinical records from the last three months were reviewed and uploaded into the resident's electronic health record. New system put into place to ensure provider documentation will be reviewed and uploaded into the resident's electronic health record to accurately reflect the resident's condition, treatment and care plan. Medical Records or Health Unit Coordinators will ensure provider documentation is reviewed and uploaded into the resident's electronic health record. The Documentation Standards policy was reviewed and remains current. Staff will be re-educated regarding the Documentation Standards policy. Reoccurrence will be prevented by: Audits of resident electronic health records will be conducted two times a week for 2 months to ensure information is true and accurate. Results of the audits will be brought to QAPI for review and further recommendation.		09/09/2026

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F0842 SS = D	Continued from page 5 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			F0842	Continued from page 5 Date of Completion: 9/9/2026 The correction will be monitored by: Director of Nursing or designee.		09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
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F0842 SS = D	Continued from page 6 This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 2 of 3 residents (R1, R3) who were noted to have missing information in their record. Findings include: Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 2 of 3 residents (R1, R3) who were noted to have missing information in their record. Findings include: R1’s face sheet identified diagnoses of diabetes, interstitial pulmonary disease (need to define this), heart failure, and chronic kidney disease. R1’s progress note dated 7/20/26, identified R1 complained of not being able to void with the past 12 hours. Left message for on-call provider of not void in past 12 hours. R1’s progress note dated 7/22/26 at 2:00 p.m., identified R1 was seen for an acute visit related to urinary concerns over the weekend. R1’s progress note dated 7/23/26, identified R1 was seen by a provider via video visit for a discharge visit. Review of R1’s electronic health record (EHR) from 7/20/26, 7/22/26, and 7/23/26 did not identify any physician notes in the facility's electronic health record (EHR). R4’s face sheet identified diagnoses of heart failure and diabetes. R4’s quarterly Minimum Data Set (MDS) dated 6/5/26, identified R4 had moderate cognitive impairment, no behaviors, no rejection of cares, needed partial/moderate assistance for transfers, and did not take a diuretic (water pill). R4’s progress note dated 7/6/26 at 6:22 a.m., identified R4 had concerns about her lungs filling up with fluid again and requested to see a doctor. R4 has had an almost 10-pound weight gain within the past week and is short of breath. In review of R4’s record, there was no indication			F0842			09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0842 SS = D	Continued from page 7 R4’s provider had been notified however, the facility obtained and provided a physician note from an outside provider electronic record system dated 7/6/26. The note practitioner note R4 had been seen for evaluation of shortness of breath and a ten-pound weight gain and concern for fluid retention. New orders for chest radiograph (Xray) to evaluate pulmonary fluid retention and laboratory studies. Further review identified the chest X-ray was response from the testing on 7/8/26. During an interview on 7/30/26 at 4:37 p.m., nurse manager registered nurse (RN)-E stated records maintained in the outside facility’s EHR were not considered part of the facility’s medical record. The facility did not routinely obtain or place copies of those records in the residents’ EHR because staff could access and review them through the outside facility’s EHR. RN-E acknowledged that not all nurses had access to the outside facility’s EHR and that, when records were not placed in the resident’s EHR, there was a risk that orders or treatments could be missed. During an interview on 7/31/26 at 12:47 p.m., nurse manager registered nurse (RN)-B stated R1’s notes dated 7/20/26, 7/22/26, and 7/23/26 were not in R1’s EHR, and a nurse practitioner note for R4 was not in R4’s EHR. RN-B explained the facility did not routinely obtain records from the outside facility’s EHR because the records were available for review in that system. The facility relied on the outside facility to fax records determined to be needed for the resident’s EHR. During an interview on 7/31/26 at 12:27 p.m., registered nurse (RN)-D stated she did not have access to the outside facility’s EHR. If RN-D needed to review a physician note, she would look for the note in the resident’s facility EHR. RN-D explained that if the note was not available in the resident’s EHR, she would be unable to review the note or verify an order for accuracy, which could result in an error. During an interview on 7/31/26 at 2:25 p.m., regional nurse consultant (RNC) stated the facility did not routinely obtain records from the outside facility’s EHR for inclusion in the resident’s EHR and only selected records were scanned into the resident’s chart. RNC acknowledged that when outside records were not reviewed and incorporated into the resident’s EHR, pertinent information could be missed. Review of the facility’s Documentation Standards			F0842			09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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F0842 SS = D	Continued from page 8 Policy dated 10/24, identified the purpose to ensure the accuracy, timeliness, and completeness of records to support clinical decision making and regulatory compliance. The policy stated all documentation must reflect the resident's condition, behaviors, care provided and any status changes. Documentation must be completed at the time of care or as soon as possible after the care is provided.			F0842			09/09/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/30/26 and 7/31/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H52183552C (3119464) with a licensing order issued at 830 and 625.			20000			09/09/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
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20000	Continued from page 1 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.			20000			09/09/2026
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520,			20625	CORRECTED		09/09/2026

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20625	Continued from page 2 subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.			20625			09/09/2026

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20625	Continued from page 3 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 2 of 3 residents (R1, R3) who were noted to have missing information in their record. Findings include: R1’s face sheet identified diagnoses of diabetes, interstitial pulmonary disease (need to define this), heart failure, and chronic kidney disease. R1’s progress note dated 7/20/26, identified R1 complained of not being able to void with the past 12 hours. Left message for on-call provider of not void in past 12 hours. R1’s progress note dated 7/22/26 at 2:00 p.m., identified R1 was seen for an acute visit related to urinary concerns over the weekend. R1’s progress note dated 7/23/26, identified R1 was seen by a provider via video visit for a discharge visit. Review of R1's electronic health record (EHR) from 7/20/26, 7/22/26, and 7/23/26 did not identify any physician notes in the facility's electronic health record (EHR). R4’s face sheet identified diagnoses of heart failure and diabetes. R4’s quarterly Minimum Data Set (MDS) dated 6/5/26, identified R4 had moderate cognitive impairment, no behaviors, no rejection of cares, needed partial/moderate assistance for transfers, and did not take a diuretic (water pill). R4’s progress note dated 7/6/26 at 6:22 a.m., identified R4 had concerns about her lungs filling up with fluid again and requested to see a doctor. R4 has had an almost 10-pound weight gain within the past week and is short of breath. In review of R4’s record, there was no indication R4’s provider had been notified however, the facility obtained and provided a physician note from an outside provider electronic record system dated 7/6/26. The note practitioner note R4 had been seen for evaluation of shortness of breath and a ten-pound weight gain and concern for fluid retention. New orders for chest radiograph (Xray) to			20625			09/09/2026

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20625	Continued from page 4 evaluate pulmonary fluid retention and laboratory studies. Further review identified the chest X-ray was response from the testing on 7/8/26. During an interview on 7/30/26 at 4:37 p.m., nurse manager registered nurse (RN)-E stated records maintained in the outside facility's EHR were not considered part of the facility's medical record. The facility did not routinely obtain or place copies of those records in the residents' EHR because staff could access and review them through the outside facility's EHR. RN-E acknowledged that not all nurses had access to the outside facility's EHR and that, when records were not placed in the resident's EHR, there was a risk that orders or treatments could be missed. During an interview on 7/31/26 at 12:47 p.m., nurse manager registered nurse (RN)-B stated R1's notes dated 7/20/26, 7/22/26, and 7/23/26 were not in R1's EHR, and a nurse practitioner note for R4 was not in R4's EHR. RN-B explained the facility did not routinely obtain records from the outside facility's EHR because the records were available for review in that system. The facility relied on the outside facility to fax records determined to be needed for the resident's EHR. During an interview on 7/31/26 at 12:27 p.m., registered nurse (RN)-D stated she did not have access to the outside facility's EHR. If RN-D needed to review a physician note, she would look for the note in the resident's facility EHR. RN-D explained that if the note was not available in the resident's EHR, she would be unable to review the note or verify an order for accuracy, which could result in an error. During an interview on 7/31/26 at 2:25 p.m., regional nurse consultant (RNC) stated the facility did not routinely obtain records from the outside facility's EHR for inclusion in the resident's EHR and only selected records were scanned into the resident's chart. RNC acknowledged that when outside records were not reviewed and incorporated into the resident's EHR, pertinent information could be missed. Review of the facility's Documentation Standards Policy dated 10/24, identified the purpose to ensure the accuracy, timeliness, and completeness of records to support clinical decision making and regulatory compliance. The policy stated all documentation must reflect the resident's condition, behaviors, care provided and any status changes. Documentation must be completed at the time of			20625			09/09/2026

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20625	Continued from page 5 care or as soon as possible after the care is provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to verifying and transcribing orders in the electronic medical record and/or develop a monitoring system to ensure resident records are true and accurate. The director of nursing or designee should educate staff and perform measurable audits. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20625	CORRECTED		09/09/2026	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess a significant weight increase and implement care-planned monitoring for edema and signs and symptoms of congestive heart failure for 1 of 3 residents (R4) reviewed for change in condition. Findings include R4's face sheet identified diagnoses of heart failure and diabetes. R4's quarterly Minimum Data Set (MDS) dated 6/5/26, identified R4 had moderate cognitive impairment, no behaviors, no rejection of cares, needed partial/moderate assistance for transfers, and did not take a diuretic (water pill). R4's care plan dated 11/20/25, identified R4 had a diagnosis of congestive heart failure. Goal to have clear lung sounds, heart rate and rhythm within		20830				

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20830	Continued from page 6 normal limits. Corresponding interventions as follows: -Give cardiac medications as ordered (dated 11/6/25). -Monitor/document/report as needed any signs and symptoms of congestive heart failure such as dependent edema of legs and feet, shortness of breath on exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles/wheezes in the lungs. Report to the provider as indicated (dated 11/6/25). -Weight as ordered (dated 1/8/26). R4's physician progress note dated 6/2/26, identified R4 had a diagnosis of chronic congestive heart failure and a coronary stent status post. No changes in treatment and continue to monitor. Review of R4's vital sign record from 5/2/26 through 7/24/26 identified the following weights: 6/5/26: 165.6 lbs. 6/12/26: 165.6 lbs. 6/26/26: 164.7 lbs. 7/3/26: 172.6 lbs. 7/24/26: 173.6 lbs. R4's weight increased from 164.7 pounds on 6/26/26 to 172.6 pounds on 7/3/26, an increase of 7.9 pounds. Review of R4's record, including the June and July Treatment Administration Records (TARs), did not identify completed edema or congestive heart failure monitoring and no indication comprehensive assessments of the weight increase were completed. R4's progress note dated 7/6/26 at 6:22 a.m., identified R4 had concerns about her lungs filling up with fluid again and requested to see a doctor. R4 has had an almost 10-pound weight gain within the past week and is short of breath. R4's nurse practitioner note dated 7/6/26, identified R4 had been seen for evaluation of shortness of breath and a ten-pound weight gain and concern for fluid retention. New orders for chest radiograph (Xray) to evaluate pulmonary fluid retention and laboratory studies.			20830			09/09/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20830	Continued from page 7 R4’s nurse practitioner note dated 7/8/26, identified results are stable and will continue to monitor. During an interview on 7/31/26 at 1:04 p.m., R4 stated she had a diagnosis of heart failure, however, does not take a “water pill” for it. R4 explained a few weeks prior she became short of breath and felt like she was filling up with fluid and had asked to see the doctor. R4 was worried she was having problems with her heart failure, explained staff needed to watch her closely to make sure “I do not get worse and must be sent to the hospital. “ During an interview on 7/31/26 at 12:47 p.m., nurse manager registered nurse (RN)-B stated R4 had diagnosis of congestive heart failure, however, her record did not have any monitoring for edema or worsening CHF symptoms. RN-B explained that a resident with a diagnosis of CHF needed to be watched closely to ensure they were not having an exacerbation of CHF and without daily monitoring that could be missed. During an interview on 7/31/26 at 1:13 p.m., RN-A stated residents with a diagnosis should be watched closely to assess for changes like shortness of breath, lung sounds, weight gain and edema, however, R4 has not been monitored for any of these on a daily basis and should be. RN-A explained by monitoring a resident with CHF closely will allow small changes to be caught quickly and get treatment for it. Review of the facility’s policy of Change of Condition Assessments dated 4/16/25, identified the purpose of the policy is to ensure timely detection, documentation, and intervention for any significant alteration in a patient’s baseline status, thereby safeguarding patient health and wellbeing. A focus assessment (a targeted approach to assessing a patient for a specific health concern or area of care. Used to evaluate the patient’s immediate needs, symptoms, or risk factors related to a particular condition, system, or issue. Requested a policy on CHF but did not receive. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to ensure residents with congestive heart failure are monitored for worsening symptoms on a routine basis and ensure provider notification of changes in a timely manner. The director of nursing or designee, could conduct random audits of physician orders; to ensure appropriate care and			20830			09/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2026	
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET , LAKE CITY, Minnesota, 55041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20830	Continued from page 8 services are implementented, TIMEFRAME FOR CORRECTION: Twenty-One (21) days.			20830			09/09/2026