P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
July 21, 2019

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

RE: Project Number H5218022C

Dear Administrator:

On July 19, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

June 21, 2019

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

RE: Project Numbers H5218020, H5218021C, H5218022C

Dear Administrator:

On May 31, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the May 31, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5218022C that was substantiated and complaint numbers H5218020, H5218021C that were found to be unsubstantiated.

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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is July 10, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 August 31, 2019 (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 December 1, 2019 (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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	C 05/31/2019

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**

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F 000	INITIAL COMMENTS On 5/28/19, 5/29/19 and 5/31/19, a abbreviated survey was completed at your facility to conduct a complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5218022C at F684 The following complaints were found not to be substantiated H5218020 and H5218021C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 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	F 684		7/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/25/2019

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.

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F 684	Continued From page 1 by: Based on interview and document review the facility failed to follow physician orders consistenly for wound care treatment for 1 of 3 residents (R1) reviewed for wound care. Findings include: A Vulnerable Adult report dated 4/13/19, indicated R1 was admitted to the facility following hospital course after having a twenty centimeter bypass surgery on R1's right leg and groin. During a telephone interview on 5/28/19, at 6:59 p.m. R1 stated she was admitted to the facility after surgery and a hospital stay of 7 days. R1 indicated at the time of admission she had two incisions, one incision by the knee and one incision that started on the upper thigh, went through the right groin, and onto the right lower part of her stomach. R1 stated the incision was very long. R1 stated she was told by the hospital staff her incisions were supposed to be cleaned with Hibiclens (antiseptic wash) two or three times daily, however, after she was admitted to the facility the staff were not doing that, she had to remind and ask staff to do it. R1 stated the first time staff had asked her how to clean the incisions and that she tried to show them the best she could however, R1 could not see the incision in the groin area because of her abdominal fold, and was not provided a mirror. R1 then stated she would clean the incision sites while in bed with the head of the bed elevated. R1 indicated that only some staff would clean the incision sites for her but otherwise told her she could do it herself, and/or would help her by holding up the abdominal fold so she could clean the area. R1 stated, her incisions were looked at daily but had	F 684	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also 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 any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs.	

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F 684	Continued From page 2 no idea who looked at them, who had helped her with cleaning, and who had performed the cleaning treatments. R1 indicated staff did not tell her what the groin incision looked like and again stated she could not see the groin area. R1's Admission Record indicated R1 was admitted on 2/27/19, with diagnoses of aortocoronary bypass graft of the extremities, diabetes type 2 with circulatory complications, peripheral vascular disease, long term use of aspirin and anticoagulants, essential hypertension, and muscle weakness. R1's discharge Minimum Data Set (MDS) dated 3/6/19, indicated R1 was cognitively intact. The MDS indicated R1 required limited assistance from one staff for transfers, bed mobility, personal hygiene, toileting, and dressing. R1's care plan provided by the facility on 5/28/19, indicated R1 had activities of daily living (ADL) self-care deficit related to recent popliteal bypass surgery with a goal of R1 would improve level of function in dressing, grooming, and hygiene and would be able to complete all task independently by discharge. The ADL care plan informed staff R1 was independent with ambulation in her room with a crutch and below the knee prosthesis, grooming was independent with set-up, required limited assist of one staff for bathing, independent with dressing, and required supervision for hygiene/oral care. R1's skin care plan included, "I have actual impairment to skin integrity related to post femoral popliteal bypass, incision sites with staples (right groin, right lower extremity) graft site, history of left lower extremity amputation, long term anticoagulation use." R1's goal indicated R1 would not have complications	F 684	R1 discharged from the facility on 3/6/2019. All licensed staff to complete education on the following: wound care documentation policy and procedures related to post-operative incisions, the importance of following physician orders for skin treatments to prevent infections, and self-administration assessments. A wound dressing competency will be completed with all licensed staff. Director of Nursing or designee to develop, implement, and monitor skin documentation audit. Audit to be completed 3x per week for two months and reviewed by the QAPI committee to determine further action if necessary. DON to ensure compliance.	

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F 684	Continued From page 3	F 684		

related to the incision sites, and directed staff to administer medication as ordered, monitor for signs and symptoms of infection at incision sites, treatments per physician orders, and weekly body audits.

R1's hospital discharge summary dated 2/27/19, included the following orders/directions:
-Call provider if you experience temperature over 100.4 degrees Fahrenheit (F), wound swelling/bleeding/redness and any concerns about the incisions.
-Right leg incisions: 1) shower or wash daily with Hibiclens dry well. 2) Mepilex (absorbent foam dressing) 3 inch x 3 inch to area of skin duskiness proximal incision. Change this 3 times a week on Monday, Wednesday, Friday. 3) Interdry (antimicrobial soft absorbent cloth) to right groin fold. Change daily and as needed if soiled/saturated. 4) may leave right thigh incision open to air.
The hospital discharge summary also included, "Right thigh wound healing well and stapled, no drainage, no signs of infection. Right groin wound with central area of dusky appearing skin edges, no breakdown, no drainage, no infection. She will need close monitoring of her right inguinal incision.

R1's facility physician incision treatment orders were inconsistent with the hospital discharge summary order; facility physician orders included:
-Hibiclens Liquid 4% to incisions topically daily (start date 2/27/19, stop date 3/4/19)
-Hibiclens Liquid 4% apply to incisions topically every day shift, cleanse incisions with wound wash or sterile water before application (start date 3/4/19, stop date 3/6/19)
-Interdry to right groin fold, change daily and as

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F 684	Continued From page 4 needed (start date 3/2/19, stop date 3/6/19) -Mepilex to area of skin duskiness proximal incision. Change every 3 days and as needed. Check every shift (start date 3/2/19, stop date 3/4/19) -Skilled charting: monitor incision sites twice per day: right leg incision/staples right groin incision/staples, graft site for any signs of infection. CWMS (color, warmth, movement, sensation) of right lower extremity twice daily (start date 2/28/19, stop date 3/6/19) R1's record was reviewed from admission on 2/27/19, through discharge on 3/6/19. R1's record also lacked evidence of treatments and/or wound care was completed consistanely per physician orders. R1's treatment administration record (TAR) for February and March 2019, were reviewed. The February TAR, indicated the Hibiclens treatment was not completed on 2/28. The March TAR indicated that the Mepilex dressing was not checked every shift once it was implemented on 3/2; the TAR had a check marked boxes with initials that indicated completion of the treatment on only the night shifts of 3/2 and 3/3/19. The March TAR also indicated the Interdry treatment, once implemented, was completed only on 3/4/19, and the Hibiclens treatment was only completed on 3/1, 3/4, and 3/5/19. The TAR's also included the order for charting the monitoring the incision. The TARs had check marked boxes with initials, which indicated when the monitoring had been completed. The TAR indicated monitoring had not been completed consistently according to physician on 3/2, both shifts on 3/3, and one shift on 3/4/19.	F 684		

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F 684	Continued From page 5 R1's Skin Alteration and Wound progress note dated 2/27/19, at 11:50 p.m. indicated right lower extremity incision with 10 staples that measured 9.0 centimeters (cm) by 1.0 cm and groin incision that measured 20.0 cm by 1.0 cm with 33 staples. R1's Skilled Charting progress note dated 3/1/19, at 1:41 p.m. included right groin incision "redness observed around the staples and black scabbing. No exudate [drainage] or warmth from site observed. Right leg incision "area appears to be healing well. No s/sx of infection." R1's record lacked evidence of the extent of the redness along the incision line had been assessed, and if the wound had improved or worsened. R1's Skin Alteration and Wounds progress note dated 3/2/19, identified the incisions on R1's right lower extremity and the measurements of the incision lines however, the skin integrity of the incisions was not mentioned. R1's physician visit note dated 3/2/19, indicated surgical incisions have not had any drainage or problems, and nursing reported no concerns. The note also included, R1 had minimal tenderness at the incision sites of the right lower extremity which were clean, dry, and appeared to be healing well. The note identified a dry dressing was reapplied over the mid-right thigh. The note further included, "nursing will continue to monitor the wound for any signs of worsening or infection and will notify senior service team if any concerns." R1's record lacked evidence the incisions were monitored/assessed/evaluated on 3/3/19. R1's Skin Alteration and Wounds progress note	F 684		

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F 684	Continued From page 6 dated 3/4/19, at 9:05 a.m. indicated, R1's surgical incision on the right lower abdomen and groin were red, appeared irritated, wound edges showed maceration, and had no drainage. The note indicated R1 had Mepilex over the incision. The Summary section of the note included, "Area appears maceration [sic], tender with dressing change. Does not appear infected. Resident reports she used interdry at precious [sic] facility. Order started yesterday to apply interdry daily. Writer cleansed wound with hibicleanse [sic]. Applied interdry. Resident reports she has a f/u [follow-up] apt [appointment] for her incision on 3/7/19." The note did not identify the extent of the redness or the maceration and did not mention the smaller incision on the right leg. R1's record lacked evidence the physician was notified of the change to the incision. R1's Skilled Charting progress note dated 3/4/19, at 9:54 p.m. indicated R1 complained of having chills and a fever of 100.5 F. R1's right lower abdomen incisional line was red, tender to touch, warm, and had drainage. The note also indicated her right thigh incision was red, warm, tender to touch, with no drainage. The note indicated the charge nurse was notified and R1's vital signs would be obtained again in 30 minutes. R1's record did not reflect the extent of the redness or type of drainage from the wound, or if the maceration around the incision had resolved. R1's Provider Visit progress note dated 3/5/19, at 11:46 a.m. indicated R1 was seen by the physician for possible wound infection. The note included, "Resident's wound on right lower abdomen per unit manager shows pus like drainage, red, tender and painful for resident.	F 684		

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F 684	Continued From page 7	F 684		

Resident had temp of 100. 5 [F]. Wound culture, labs and order for IV abx [intravenous antibiotic] placed. Resident is planning on DC [discharge] from facility on Saturday which [physician] also said may need to be changed r/t [related to] wound infection. Resident is agreeable to this." Subsequent progress notes on 3/5/19, indicated the photos were taken of the incision, the surgeon was updated on the wound status, new antibiotic ordered, and indicated R1 was to see the surgeon on 3/6/19.

R1's progress note dated 3/6/19, at 9:26 a.m. indicated R1 had been admitted to the hospital.

During interview on 5/29/19, at 8:17 a.m. registered nurse (RN)-A nurse manager and RN-B the facility infection preventionist were interviewed. RN-A confirmed the discharge summary directed staff to apply Mepilex to the dusky areas of the incision. RN-B confirmed that the order was not transcribed and/or implemented until 3/2/19, and should have been on the orders upon admission. RN-A stated she didn't think the Mepilex was on the incision from 2/27 through 3/2. She indicated that upon review of the admission orders, staff realized it was omitted and the dressing was applied on 3/2. RN-B indicated the area of duskiness was difficult to assess because staff couldn't tell where it was and the discharge summary was not clear as it didn't have measurements or location. RN-B indicated the hospital was not contacted for clarification. RN-B reviewed R1's record and confirmed the Hibiclens was not documented as completed, and indicated if the box on the TAR was not checked, that indicates the treatment was not done. RN-B further verified the order for Intradry was not transcribed into the physician

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F 684	Continued From page 8 orders upon admission, and confirmed according to R1's TAR the Interdry was not used according to physician orders. On 5/29/19, at 10:24 a.m. physician (MD)-A stated R1 was evaluated on 3/5/19, MD-A indicated that documenting assessments and monitoring was part of what nurses needed to do however, did not rely and/or review that documentation. MD-A indicated expectation for physician orders to be followed and stated cleaning externally would not ultimately prevent an infection from occurring especially with closed incisions with staples or sutures. During an interview on 5/29/19, at 2:30 p.m. the director of nursing (DON) and administrator were interviewed. Administrator stated and confirmed R1's record lacked documentation of wound care and monitoring /evaluation /assessments. DON indicated he would expect nurses to follow physician orders. DON reviewed R1's record and confirmed there was a lack of documentation on R1's incisional monitoring and evaluations/assessments. Facility policy Management of Skin Alterations dated 3/2018, included, To ensure necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections, alterations from worsening, and new injuries from developing. 1) Upon admission each resident will have a Braden assessment and comprehensive skin risk assessment for determination of risk. Appropriate interventions will be implemented based on assessment and will be placed on resident care plan. 2) weekly each resident will have a body audit	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING ______ B. WING ______	C 05/31/2019

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F 684	Continued From page 9 performed by licensed nurse for identification of any alterations in skin integrity. 3) residents will be observed daily and as needed. 4) With identification of any change in skin integrity a checklist for skin alterations and wounds will be implemented. The corresponding checklist directed staff to initiate daily skin alteration and/or wound site monitoring.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 21, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Numbers H5218020, H5218021C, H5218022C

Dear Administrator:

A complaint investigation was completed on . At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	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 5/28/19, 5/29/19 and 5/31/19, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/25/19

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5218022C Correction orders issued at MN Rule 4658.0520 Subp.1 The following complaints were found not to be substantiated: H5218020 and H5218021C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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 MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow physician orders consistenly for wound care treatment for 1 of 3 residents (R1)	2 830	R1 discharged from the facility on 3/6/2019. All licensed staff to complete education on	7/12/19

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2 830	Continued From page 2 reviewed for wound care. Findings include: A Vulnerable Adult report dated 4/13/19, indicated R1 was admitted to the facility following hospital course after having a twenty centimeter bypass surgery on R1's right leg and groin. During a telephone interview on 5/28/19, at 6:59 p.m. R1 stated she was admitted to the facility after surgery and a hospital stay of 7 days. R1 indicated at the time of admission she had two incisions, one incision by the knee and one incision that started on the upper thigh, went through the right groin, and onto the right lower part of her stomach. R1 stated the incision was very long. R1 stated she was told by the hospital staff her incisions were supposed to be cleaned with Hibiclens (antiseptic wash) two or three times daily, however, after she was admitted to the facility the staff were not doing that, she had to remind and ask staff to do it. R1 stated the first time staff had asked her how to clean the incisions and that she tried to show them the best she could however, R1 could not see the incision in the groin area because of her abdominal fold, and was not provided a mirror. R1 then stated she would clean the incision sites while in bed with the head of the bed elevated. R1 indicated that only some staff would clean the incision sites for her but otherwise told her she could do it herself, and/or would help her by holding up the abdominal fold so she could clean the area. R1 stated, her incisions were looked at daily but had no idea who looked at them, who had helped her with cleaning, and who had performed the cleaning treatments. R1 indicated staff did not tell her what the groin incision looked like and again stated she could not see the groin area.	2 830	the following: wound care documentation policy and procedures, the importance of following physician orders for skin treatments to prevent infections, and self-administration assessments. A wound dressing competency will be completed with all licensed staff. Director of Nursing or designee to develop, implement, and monitor skin documentation audit. Audit to be completed 3x per week for two months and reviewed by the QAPI committee to determine further action if necessary. DON to ensure compliance.	

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2 830	Continued From page 3	2 830		

R1's Admission Record indicated R1 was admitted on 2/27/19, with diagnoses of aortocoronary bypass graft of the extremities, diabetes type 2 with circulatory complications, peripheral vascular disease, long term use of aspirin and anticoagulants, essential hypertension, and muscle weakness.

R1's discharge Minimum Data Set (MDS) dated 3/6/19, indicated R1 was cognitively intact. The MDS indicated R1 required limited assistance from one staff for transfers, bed mobility, personal hygiene, toileting, and dressing.

R1's care plan provided by the facility on 5/28/19, indicated R1 had activities of daily living (ADL) self-care deficit related to recent popliteal bypass surgery with a goal of R1 would improve level of function in dressing, grooming, and hygiene and would be able to complete all task independently by discharge. The ADL care plan informed staff R1 was independent with ambulation in her room with a crutch and below the knee prosthesis, grooming was independent with set-up, required limited assist of one staff for bathing, independent with dressing, and required supervision for hygiene/oral care. R1's skin care plan included, "I have actual impairment to skin integrity related to post femoral popliteal bypass, incision sites with staples (right groin, right lower extremity) graft site, history of left lower extremity amputation, long term anticoagulation use." R1's goal indicated R1 would not have complications related to the incision sites, and directed staff to administer medication as ordered, monitor for signs and symptoms of infection at incision sites, treatments per physician orders, and weekly body audits.

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2 830	Continued From page 4 R1's hospital discharge summary dated 2/27/19, included the following orders/directions: -Call provider if you experience temperature over 100.4 degrees Fahrenheit (F), wound swelling/bleeding/redness and any concerns about the incisions. -Right leg incisions: 1) shower or wash daily with Hibiclens dry well. 2) Mepilex (absorbent foam dressing) 3 inch x 3 inch to area of skin duskiness proximal incision. Change this 3 times a week on Monday, Wednesday, Friday. 3) Interdry (antimicrobial soft absorbent cloth) to right groin fold. Change daily and as needed if soiled/saturated. 4) may leave right thigh incision open to air. The hospital discharge summary also included, "Right thigh wound healing well and stapled, no drainage, no signs of infection. Right groin wound with central area of dusky appearing skin edges, no breakdown, no drainage, no infection. She will need close monitoring of her right inguinal incision. R1's facility physician incision treatment orders were inconsistent with the hospital discharge summary order; facility physician orders included: -Hibiclens Liquid 4% to incisions topically daily (start date 2/27/19, stop date 3/4/19) -Hibiclens Liquid 4% apply to incisions topically every day shift, cleanse incisions with wound wash or sterile water before application (start date 3/4/19, stop date 3/6/19) -Interdry to right groin fold, change daily and as needed (start date 3/2/19, stop date 3/6/19) -Mepilex to area of skin duskiness proximal incision. Change every 3 days and as needed. Check every shift (start date 3/2/19, stop date 3/4/19) -Skilled charting: monitor incision sites twice per day: right leg incision/staples right groin	2 830		

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2 830	Continued From page 5	2 830		

incision/staples, graft site for any signs of infection. CWMS (color, warmth, movement, sensation) of right lower extremity twice daily (start date 2/28/19, stop date 3/6/19)

R1's record was reviewed from admission on 2/27/19, through discharge on 3/6/19. R1's record also lacked evidence of treatments and/or wound care was completed consistanely per physician orders.

R1's treatment administration record (TAR) for February and March 2019, were reviewed. The February TAR, indicated the Hibiclens treatment was not completed on 2/28. The March TAR indicated that the Mepilex dressing was not checked every shift once it was implemented on 3/2; the TAR had a check marked boxes with initials that indicated completion of the treatment on only the night shifts of 3/2 and 3/3/19. The March TAR also indicated the Interdry treatment, once implemented, was completed only on 3/4/19, and the Hibiclens treatment was only completed on 3/1, 3/4, and 3/5/19. The TAR's also included the order for charting the monitoring the incision. The TARs had check marked boxes with initials, which indicated when the monitoring had been completed. The TAR indicated monitoring had not been completed consistently according to physician on 3/2, both shifts on 3/3, and one shift on 3/4/19.

R1's Skin Alteration and Wound progress note dated 2/27/19, at 11:50 p.m. indicated right lower extremity incision with 10 staples that measured 9.0 centimeters (cm) by 1.0 cm and groin incision that measured 20.0 cm by 1.0 cm with 33 staples.

R1's Skilled Charting progress note dated 3/1/19, at 1:41 p.m. included right groin incision "redness

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2 830	Continued From page 6	2 830		

observed around the staples and black scabbing. No exudate [drainage] or warmth from site observed. Right leg incision "area appears to be healing well. No s/sx of infection." R1's record lacked evidence of the extent of the redness along the incision line had been assessed, and if the wound had improved or worsened.

R1's Skin Alteration and Wounds progress note dated 3/2/19, identified the incisions on R1's right lower extremity and the measurements of the incision lines however, the skin integrity of the incisions was not mentioned.

R1's physician visit note dated 3/2/19, indicated surgical incisions have not had any drainage or problems, and nursing reported no concerns. The note also included, R1 had minimal tenderness at the incision sites of the right lower extremity which were clean, dry, and appeared to be healing well. The note identified a dry dressing was reapplied over the mid-right thigh. The note further included, "nursing will continue to monitor the wound for any signs of worsening or infection and will notify senior service team if any concerns."

R1's record lacked evidence the incisions were monitored/assessed/evaluated on 3/3/19.

R1's Skin Alteration and Wounds progress note dated 3/4/19, at 9:05 a.m. indicated, R1's surgical incision on the right lower abdomen and groin were red, appeared irritated, wound edges showed maceration, and had no drainage. The note indicated R1 had Mepilex over the incision. The Summary section of the note included, "Area appears maceration [sic], tender with dressing change. Does not appear infected. Resident reports she used interdry at precious [sic] facility.

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Order started yesterday to apply interdry daily. Writer cleansed wound with hibicleanse [sic]. Applied interdry. Resident reports she has a f/u [follow-up] apt [appointment] for her incision on 3/7/19." The note did not identify the extent of the redness or the maceration and did not mention the smaller incision on the right leg.

R1's record lacked evidence the physician was notified of the change to the incision.

R1's Skilled Charting progress note dated 3/4/19, at 9:54 p.m. indicated R1 complained of having chills and a fever of 100.5 F. R1's right lower abdomen incisional line was red, tender to touch, warm, and had drainage. The note also indicated her right thigh incision was red, warm, tender to touch, with no drainage. The note indicated the charge nurse was notified and R1's vital signs would be obtained again in 30 minutes. R1's record did not reflect the extent of the redness or type of drainage from the wound, or if the maceration around the incision had resolved.

R1's Provider Visit progress note dated 3/5/19, at 11:46 a.m. indicated R1 was seen by the physician for possible wound infection. The note included, "Resident's wound on right lower abdomen per unit manager shows pus like drainage, red, tender and painful for resident. Resident had temp of 100. 5 [F]. Wound culture, labs and order for IV abx [intravenous antibiotic] placed. Resident is planning on DC [discharge] from facility on Saturday which [physician] also said may need to be changed r/t [related to] wound infection. Resident is agreeable to this." Subsequent progress notes on 3/5/19, indicated the photos were taken of the incision, the surgeon was updated on the wound status, new antibiotic ordered, and indicated R1 was to see the

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2 830	Continued From page 8	2 830		

surgeon on 3/6/19.

R1's progress note dated 3/6/19, at 9:26 a.m. indicated R1 had been admitted to the hospital.

During interview on 5/29/19, at 8:17 a.m. registered nurse (RN)-A nurse manager and RN-B the facility infection preventionist were interviewed. RN-A confirmed the discharge summary directed staff to apply Mepilex to the dusky areas of the incision. RN-B confirmed that the order was not transcribed and/or implemented until 3/2/19, and should have been on the orders upon admission. RN-A stated she didn't think the Mepilex was on the incision from 2/27 through 3/2. She indicated that upon review of the admission orders, staff realized it was omitted and the dressing was applied on 3/2. RN-B indicated the area of duskiness was difficult to assess because staff couldn't tell where it was and the discharge summary was not clear as it didn't have measurements or location. RN-B indicated the hospital was not contacted for clarification. RN-B reviewed R1's record and confirmed the Hibiclens was not documented as completed, and indicated if the box on the TAR was not checked, that indicates the treatment was not done. RN-B further verified the order for Intradry was not transcribed into the physician orders upon admission, and confirmed according to R1's TAR the Interdry was not used according to physician orders.

On 5/29/19, at 10:24 a.m. physician (MD)-A stated R1 was evaluated on 3/5/19, MD-A indicated that documenting assessments and monitoring was part of what nurses needed to do however, did not rely and/or review that documentation. MD-A indicated expectation for physician orders to be followed and stated

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2 830	Continued From page 9	2 830		

Continued From page 9

cleaning externally would not ultimately prevent an infection from occurring especially with closed incisions with staples or sutures.

During an interview on 5/29/19, at 2:30 p.m. the director of nursing (DON) and administrator were interviewed. Administrator stated and confirmed R1's record lacked documentation of wound care and monitoring /evaluation /assessments. DON indicated he would expect nurses to follow physician orders. DON reviewed R1's record and confirmed there was a lack of documentation on R1's incisional monitoring and evaluations/assessments.

Facility policy Management of Skin Alterations dated 3/2018, included, To ensure necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections, alterations from worsening, and new injuries from developing.
1) Upon admission each resident will have a Braden assessment and comprehensive skin risk assessment for determination of risk. Appropriate interventions will be implemented based on assessment and will be placed on resident care plan.
2) weekly each resident will have a body audit performed by licensed nurse for identification of any alterations in skin integrity.
3) residents will be observed daily and as needed.
4) With identification of any change in skin integrity a checklist for skin alterations and wounds will be implemented. The corresponding checklist directed staff to initiate daily skin alteration and/or wound site monitoring.

Suggested Method of Correction: The Director of Nursing or designee could review policies and

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00770	A. BUILDING: ______ B. WING ______	C 05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	**500 WEST GRANT STREET LAKE CITY, MN 55041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 procedures, train staff, and implement measures to monitor evaluate/assess post operative incisions in order to timely identify changes to skin integrity. In addition the facility could re-educate staff on importance of following physician orders for skin treatments in order to reduce the risk of infections. The facility could then develop and implement and auditing system as part of their quality assurance activities in order to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		