MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Mayo Clinic Health System Fairmont	H5274006	December 13, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
800 Medical Center Drive	9:30 a.m. - 4:15 p.m.	March 13, 2017
Facility City:	**Investigator's Name and Title:**	
Fairmont	Christie Bluhm, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	56031	Martin

☒ **Nursing Home**

Allegation(s):

It is alleged that the resident sustained a burn to the left foot when the resident's foot was leaning against the baseboard heater.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the facility staff failed to ensure the resident's bed was a safe distance away from the room's baseboard heater. The resident's bed was positioned against the baseboard heater. The resident sustained a burn and blister to his/her left foot after his/her foot was found resting on the heater.

The resident's diagnoses included end-stage supra nuclear palsy (deterioration of cells in areas of the brain that control body movement and thinking) and parkinson's disease. The resident was unable to reposition independently and required extensive assist of two staff for bed mobility. The resident was minimally responsive and non-verbal.

The resident received turn and reposition checks every two hours per his/her care plan. One night during midnight checks, the resident was noted to be very warm, sweating profusely and hypotensive, with a body temperature of 101.3 Fahrenheit. The resident's bed was observed to be touching the baseboard heater and the resident's left foot was resting on the heater. After further assessment, a burn was noted on the resident's left foot. A blister formed that measured 8 centimeters (cm) by 6.3 cm. The physician and hospice team were contacted and provided treatment and monitoring orders. Staff treated the burn with dressings and continued to monitor.

Staff immediately rearranged the room so the resident's bed was not positioned against the heater. The charge nurse instructed the direct care staff to check all resident rooms to ensure all resident beds were a

safe distance away from the baseboard heaters.

The resident died three days later on hospice care. The death certificate indicated the resident died of natural causes due to his/her diagnoses of progressive supra nuclear palsy and parkinson's disease.

The facility developed a new policy regarding bed furniture placement in the resident rooms, and scheduled audits to ensure policy is being followed.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility did not have a policy in place regarding bed arrangements in resident's rooms. Staff had observed the resident's bed in the position near the heat register, without identifying the potential safety hazard.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

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Fairmont

Report Number: H5274006

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Care Guide

- [x] Nurses Notes
- [x] Assessments
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Death Certificate

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Five

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Resident is deceased.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Resident is deceased.

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Eight

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Injury

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ◉ Yes ○ No Specify: Bed furniture placement.

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Fairmont Police Department

Fairmont City Attorney

Martin County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245274	A. BUILDING _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5274006. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

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

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 323	Continued From page 1 Based on interview and document review, the facility failed to ensure a resident's environment was free of hazards for 1 of 6 resident's (R1) reviewed. R1's bed was up against the baseboard heating unit. This resulted in a burn with blister on R1's left foot. Findings include: Review of R1's medical record revealed a diagnosis of Parkinson's disease and progressive supranuclear ophthalmoplegia (deterioration of cells in areas of the brain that control body movement, which may cause immobility.) The quarterly Minimum Data Set (MDS) dated 11/8/16 indicated R1's functional status required extensive assist and two staff for bed mobility. R1's care plan dated 11/18/16 indicated R1's bed mobility required extensive to total assistance of one to two staff. R1 also needed the use of a Hoyer lift for transfers and repositioning every two hours. A nursing progress note dated 12/8/16 at 2:39 a.m. indicated nursing aide (NA)-A asked registered nurse (RN)-F to check on R1. RN-F documented that the R1 was warm and sweating and that her left foot was against the baseboard heater. R1's temperature was 107 Fahrenheit. A Tylenol suppository was given for the fever and cold packs were placed under R1's arms and on R1's forehead. R1 had redness to the entire left calf and on the top of the left foot. A blister was present that extended to the great toe and second toe. The room was rearranged so bed was not against wall and foot cradle placed to bed to protect blister on the foot.	F 323		

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F 323	Continued From page 2 A nursing progress note dated 12/8/16 at 4:58 a.m., noted the left foot blister continued to accumulate fluid. The skin over the blister was taught. R1 showed no signs of discomfort. R1's temperature was rechecked and it was then 101.3 Fahrenheit. A nursing progress note dated 12/8/16 at 8:14 indicated that it was a late entry note, and that hospice was notified of burn R1 received during the night. An email written by the director of nursing (DON), dated 12/8/16 at 10:24 a.m., to facility staff, informed all that "Beds should not be against the outside walls. Please put a bedside stand between the wall and the bed so we do not push them to the wall. Explain the safety risk to residents and their families of having the bed against the outside wall with the heater." A nursing progress note dated 12/8/16 at 1:01 p.m. indicated R1's burn was checked at 7:15 a.m. and the blister was still closed and left open to air. A hospice progress note dated 12/8/16 at 9:37 p.m., indicated the blister was still fluid filled on the top of the left foot. The left first and fourth toe as well as the left shin are red in color. R1 was noted to jerk foot when toes were touched. R1 was taking only liquid medications for comfort at that time. During interview on 12/13/16 at 11:45 a.m., NA-A stated that she was last in R1's room around 10:30 p.m. to pass towels but did not check R1's position in the bed. On 12/8/16 at 12:03 a.m.,	F 323		

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F 323	Continued From page 3 NA-A and another staff person entered the room for the scheduled bed check to turn and reposition R1. R1 was lying on her right side facing the wall covered by blankets up to her shoulders. When blankets were removed, her left leg was hot and up against the baseboard heater. The bed mattress was also up against the baseboard heater. NA-A immediately notified RN-F. During an interview on 12/22/16 at 3:30 p.m., RN-F stated when she assessed R1 on 12/8/16 after NA-A's request, a blister was forming on the top of her left foot. R1 did not appear to be in distress. RN-F instructed staff to move the night stand between the bed and the baseboard heater. An interview with family member FM-G on 12/30/16 stated that prior to the incident, the resident's bed was usually next to the wall heater with "no gaps", and at the time of the incident, R1 couldn't move herself. During an interview with the DON on 12/13/16 at 3:40 p.m., she stated there was not a procedure in place ensuring there should never be a bed against the heater or air conditioner unit. Interview with maintenance staff (B) on 12/13/16 at 11:20 a.m., stated that resident's will push the bed right up against the radiator unit. A temperature gun used registered the surface temperature of the baseboard heater at 108 degrees Fahrenheit the night of the incident.	F 323		

Minnesota Department of Health

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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: A complaint investigation was conducted to investigate complaint #H5274006. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's environment was free of hazards for 1 of 6 resident's (R1) reviewed. R1's bed was up against the baseboard heating unit. This resulted in a burn with blister on R1's left foot. Findings include: Review of R1's medical record revealed a diagnosis of Parkinson's disease and progressive supranuclear ophthalmoplegia (deterioration of cells in areas of the brain that control body movement, which may cause immobility.) The quarterly Minimum Data Set (MDS) dated	21665		

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21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in	21850		

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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) COMPLETE DATE
21850	Continued From page 5 section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident was free from maltreatment and the environment was free of hazards when 1 of 6 resident's (R1)'s bed was up against the heating unit. This resulted in a burn with blister on R1's left foot. Based on interview and document review, the facility failed to ensure a resident's environment was free of hazards for 1 of 6 resident's (R1) reviewed. R1's bed was up against the baseboard heating unit. This resulted in a burn with blister on R1's left foot. Findings include: Review of R1's medical record revealed a diagnosis of Parkinson's disease and progressive supranuclear ophthalmoplegia (deterioration of cells in areas of the brain that control body movement, which may cause immobility.) The quarterly Minimum Data Set (MDS) dated 11/8/16 indicated R1's functional status required extensive assist and two staff for bed mobility.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00359	A. BUILDING: _____ B. WING _____	C 01/12/2017

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MAYO CLINIC HEALTH SYSTEM - FAIRMONT	800 MEDICAL CENTER DRIVE, PO BOX 800 FAIRMONT, MN 56031

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21850	Continued From page 6 R1's care plan dated 11/18/16 indicated R1's bed mobility required extensive to total assistance of one to two staff. R1 also needed the use of a Hoyer lift for transfers and repositioning every two hours. A nursing progress note dated 12/8/16 at 2:39 a.m. indicated nursing aide (NA)-A asked registered nurse (RN)-F to check on R1. RN-F documented that the R1 was warm and sweating and that her left foot was against the baseboard heater. R1's temperature was 107 Fahrenheit. A Tylenol suppository was given for the fever and cold packs were placed under R1's arms and on R1's forehead. R1 had redness to the entire left calf and on the top of the left foot. A blister was present that extended to the great toe and second toe. The room was rearranged so bed was not against wall and foot cradle placed to bed to protect blister on the foot. A nursing progress note dated 12/8/16 at 4:58 a.m., noted the left foot blister continued to accumulate fluid. The skin over the blister was taught. R1 showed no signs of discomfort. R1's temperature was rechecked and it was then 101.3 Fahrenheit. A nursing progress note dated 12/8/16 at 8:14 indicated that it was a late entry note, and that hospice was notified of burn R1 received during the night. An email written by the director of nursing (DON), dated 12/8/16 at 10:24 a.m., to facility staff, informed all that "Beds should not be against the outside walls. Please put a bedside stand between the wall and the bed so we do not push them to the wall. Explain the safety risk to	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21850	Continued From page 7 residents and their families of having the bed against the outside wall with the heater." A nursing progress note dated 12/8/16 at 1:01 p.m. indicated R1's burn was checked at 7:15 a.m. and the blister was still closed and left open to air. A hospice progress note dated 12/8/16 at 9:37 p.m., indicated the blister was still fluid filled on the top of the left foot. The left first and fourth toe as well as the left shin are red in color. R1 was noted to jerk foot when toes were touched. R1 was taking only liquid medications for comfort at that time. During interview on 12/13/16 at 11:45 a.m., NA-A stated that she was last in R1's room around 10:30 p.m. to pass towels but did not check R1's position in the bed. On 12/8/16 at 12:03 a.m., NA-A and another staff person entered the room for the scheduled bed check to turn and reposition R1. R1 was lying on her right side facing the wall covered by blankets up to her shoulders. When blankets were removed, her left leg was hot and up against the baseboard heater. The bed mattress was also up against the baseboard heater. NA-A immediately notified RN-F. During an interview on 12/22/16 at 3:30 p.m., RN-F stated when she assessed R1 on 12/8/16 after NA-A's request, a blister was forming on the top of her left foot. R1 did not appear to be in distress. RN-F instructed staff to move the night stand between the bed and the baseboard heater. An interview with family member FM-G on 12/30/16 stated that prior to the incident, the	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21850	Continued From page 8 resident's bed was usually next to the wall heater with "no gaps", and at the time of the incident, R1 couldn't move herself. During an interview with the DON on 12/13/16 at 3:40 p.m., she stated there was not a procedure in place ensuring there should never be a bed against the heater or air conditioner unit. Interview with maintenance staff (B) on 12/13/16 at 11:20 a.m., stated that resident's will push the bed right up against the radiator unit. A temperature gun used registered the surface temperature of the baseboard heater at 108 degrees Fahrenheit the night of the incident. The facility policy titled: Adult Abuse and Neglect prevention plan dated 12/96 defined neglect as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could create interventions to ensure resident's furniture are not placed directly next to heat and cooling unit sources that have the potential to cause injury. The administrator and/or designee could provide monitoring for compliance and effectiveness of the policy interventions as necessary in accordance with current standards of practice. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21850		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

May 17, 2017

Ms. Amy Long, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive, PO Box 800
Fairmont, MN 56031

Re: Enclosed Reinspection Results - Complaint Number H5274006

Dear Ms. Long:

On February 21, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on January 12, 2017. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 17, 2017

Ms. Amy Long, Administrator
Mayo Clinic Health System - Fairmont
800 Medical Center Drive, PO Box 800
Fairmont, MN 56031

RE: Project Number H5274006

Dear Ms. Long:

On January 24, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 29, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on January 12, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 21, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant toan abbreviated standard survey, completed on January 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 2, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on January 12, 2017, as of February 21, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 21, 2017

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of No DATA

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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
Minnesota Department of Health
Licensing and Certification Program
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