

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245218                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Mayo Clinic Health System - Lake City                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>500 West Grant Street<br>Lake City, MN 55041 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                                                 |
| F 0684<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 [DATE], 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 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 (continued on next page) |                                                                                           |                                                 |

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.

|                                                                          |           |                        |
|--------------------------------------------------------------------------|-----------|------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE     | (X6) DATE              |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID: | Facility ID:<br>245218 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245218                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Mayo Clinic Health System - Lake City                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>500 West Grant Street<br>Lake City, MN 55041 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                 |
| F 0684<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>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.</p> |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245218                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Mayo Clinic Health System - Lake City                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>500 West Grant Street<br>Lake City, MN 55041 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                                                 |
| F 0775<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Keep complete, dated laboratory records in the resident's record.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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. |                                                                                           |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245218                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Mayo Clinic Health System - Lake City                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>500 West Grant Street<br>Lake City, MN 55041 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                           |                                                 |
| <p>F 0842</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 [DATE], 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 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 (continued on next page)</p> |                                                                                           |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245218                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/31/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Mayo Clinic Health System - Lake City                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>500 West Grant Street<br>Lake City, MN 55041 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                           |                                                 |
| F 0842<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | 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 care or as soon as possible after the care is provided. |                                                                                           |                                                 |