

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 7015 0640 0003 5694 3603

December 6, 2016

Mr. Jason Nelson, Administrator Lake Ridge Care Center of Buffalo 310 Lake Boulevard Buffalo, Minnesota 55313

RE: Lake Ridge Care Center of Buffalo; Independent Informal Dispute Resolution (IIDR)

CMS Certification Number (CCN): 24 5513

Project Number: S5513025 Complaint Investigation Number: H5513019

Dear Mr. Nelson:

In a request dated November 25, 2016, Lake Ridge Care Center of Buffalo requested removal of deficiencies cited at F241 and F323, as a result of a recertification survey and substantiated complaint investigation completed on October 26, 2015 by the Licensing and Certification Program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated June 16th, 2016. This includes removal of the corresponding State licensing orders cited at *2 1665* and *2 1805*.

In addition, the Department has posted the revised results electronically since the facility is an active user of the electronic Plan of Correction (ePoC) system.

The revised CMS 2567, State form, CMS 2567b and State Form: Revisit Report are enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Holly Kranz, RN, Nursing Evaluator II

cc: Office of Ombudsman for Long-Term Care Mary Absolon, Program Manager Pam Kerssen, Assistant Program Manager Licensing and Certification File

Hally Kranz

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-
IDENTIFICATION NUMBER	A. Building			
245513 _{Y1}	B. Wing	Y2	1/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF	BUFFALO	310 LAKE BOULEVARD		
		BUFFALO, MN 55313		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	М	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0156	Correction	ID Prefix	F0157	Correction	ID Prefix	F0166		Correction
Reg.#	483.10(b)(5) - (10 483.10(b)(1)), Completed	Reg. #	83.10(b)(11)	Completed	Reg. #	483.10(f)(2)		Completed
LSC		12/29/2015	LSC		12/29/2015	LSC			12/29/2015
ID Prefix	F0167	Correction	ID Prefix	F0225	Correction	ID Prefix	F0226		Correction
Reg.#	483.10(g)(1)	Completed	Reg. #	.83.13(c)(1)(ii)-(iii), (c)(2) (4)	Completed	Reg. #	483.13(c)		Completed
LSC		12/29/2015	LSC		12/29/2015	LSC			12/29/2015
ID Prefix	F0242	Correction	ID Prefix	F0244	Correction	ID Prefix	F0250		Correction
Reg.#	483.15(b)	Completed	Reg. #	.83.15(c)(6)	Completed	Reg. #	483.15(g)(1)		Completed
LSC		12/29/2015	LSC		12/29/2015	LSC			12/29/2015
ID Prefix	F0282	Correction	ID Prefix	F0285	Correction	ID Prefix	F0309		Correction
Reg.#	483.20(k)(3)(ii)	Completed	Reg. #	.83.20(m), 483.20(e)	Completed	Reg. #	483.25		Completed
LSC		12/29/2015	LSC		12/29/2015	LSC			12/29/2015
ID Prefix	F0312	Correction	ID Prefix	F0315	Correction	ID Prefix	F0333		Correction
Reg.#	483.25(a)(3)	Completed	Reg. #	.83.25(d)	Completed	Reg. #	483.25(m)(2)		Completed
LSC		12/29/2015	LSC		- 12/29/2015 -	LSC			12/29/2015
REVIEWE		REVIEWED BY (INITIALS) BF/mm	DATE 12/06/20	SIGNATURE OF SI	urveyor 35575			DATE 01/2	1/2016
REVIEWE	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	

POST-CERTIFICATION REVISIT REPORT

	R / SUPPLIEF			MULTIPLE CONST	RUCTION							DATE OF	REVISIT
245513			Y1	B. Wing							Y2	1/21/20	16 _{Y3}
NAME OF	FACILITY								ADDRESS, CITY	Y, STATE, ZIF	CODE		
LAKE RIE	OGE CARE	CENTE	ER OF I	BUFFALO					E BOULEVARD .O, MN 55313				
program, corrected provision	to show tho and the dat	se defi te such d the id	ciencie: correct	s previously reportive action was ac	ted on the complished	CMS-25 I. Each	67, Statem deficiency	and/or Cl nent of D should I	inical Laborator reficiencies and be fully identified	Plan of Cor	ent Amendments rection, that have er the regulation of of each requireme	r LSC	
ITEN	И			DATE	ITEM				DATE	ITEM			DATE
Y4				Y5	Y4				Y5	Y4			Y5
ID Prefix	F0353			Correction	ID Prefix	F0356			Correction	ID Prefix	F0371		Correction
Reg.#	483.30(a)			Completed	Reg.#	483.30(e)		Completed	Reg.#	483.35(i)		Completed
LSC				12/29/2015	LSC				12/29/2015	LSC			12/29/2015
ID Prefix	F0412			Correction	ID Prefix	F0428		<u> </u>	Correction	ID Prefix	F0441		Correction
Reg.#	483.55(b)			Completed	Reg. #	483.60(c)		Completed	Reg. #	483.65		Completed
LSC				12/29/2015	LSC				12/29/2015	LSC			12/29/2015
ID Prefix	F0490			Correction	ID Prefix	F0520		7	Correction				
Reg.#	483.75			Completed	Reg. #	483.75(0)(1)		Completed				
LSC				12/29/2015	LSC				12/29/2015				
REVIEWEI STATE AG			REVIEW		DATE 12/06/2	2016	SIGNATUR	RE OF SU	RVEYOR 35575			DATE 01/21	/2016
REVIEWEI	D BY	-	REVIEW	ED BY	DATE		TITLE					DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/26/2015				_				D DEFICIENCIES CMS-2567) SENT			YES	□ NO	

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/	26/2015
	ROVIDER OR SUPPLIER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	FC	000			
F 156 SS=D	Department of Heathrough October 26 In addition a completed for H55 which resulted in a The facility's plan of as your allegation of Department's acceenrolled in ePOC, at the bottom of the form. Your electron be used as verificate Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. 483.10(b)(5) - (10). RIGHTS, RULES, The facility must in and in writing in a lunderstands of his regulations governing responsibilities dur facility must also protice (if any) of the made prior to or upresident's stay. Resident's stay.	aint investigation was 13019, and was substantiated deficiency at F353. If correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with the en attained in accordance with or her rights and all rules and ing resident conduct and ing the stay in the facility. The rovide the resident with the estate developed under Act. Such notification must be not admission and during the step of such information, and	F 1	56			12/29/15
ADODATOD	writing.	o it, must be acknowledged in DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

11/27/2015

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310	EET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD FFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	The facility must infentitled to Medicaid of admission to the resident becomes eitems and services facility services und which the resident other items and ser and for which the resident to the amount of charginform each resident the items and servi (i)(A) and (B) of this The facility must infat the time of admist the resident's stay, facility and of chargincluding any chargincluding any chargincluding any chargincluding any charging under Medicare or The facility must full legal rights which in A description of the funds, under parage A description of the for establishing eligithe right to request 1924(c) which detenon-exempt resour institutionalization a spouse an equitable cannot be consider toward the cost of the	form each resident who is benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing ler the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and at when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or esion, and periodically during of services available in the less for those services, les for services not covered by the facility's per diem rate. Formish a written description of includes: In manner of protecting personal raph (c) of this section; I requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment the institutionalized spouse's or her process of spending	F 1	56			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	A posting of names numbers of all perigroups such as the agency, the State ombudsman progradvocacy network, unit; and a stateme complaint with the agency concerning misappropriation of facility, and non-codirectives requirem. The facility must in name, specialty, and physician responsion. The facility must physician responsion of the facility must physician for adminformation about Medicare and Medicare and Medicare refunds for such benefits.	s, addresses, and telephone tinent State client advocacy e State survey and certification licensure office, the State am, the protection and and the Medicaid fraud control ent that the resident may file a State survey and certification gresident abuse, neglect, and of resident property in the ampliance with the advance	F 1	56			
	Based on interview facility failed to ensure provided the non-coverage upon services. Findings include: A facility Admission	w and document review, the sure 1 of 3 residents (R98) required notice of Medicare n termination of the covered			F156-D Facility timely submits this respons plan of correction pursuant to feder state law requirements. This response and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficiency of the correctly cited or factually based it's not to be construed as an admits	ral and onse ssions does ency ed and	
		n/Leave/Discharge Tracking			it's not to be construed as an admis	ssion	

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION			. ,	IPLE CONSTRUCTION NG		SURVEY PLETED
		245513	B. WING _		10/2	26/2015
NAME OF PROVIDER OR SU		OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		0,2010
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
"Medicare P 32 days. R98's medicinformation of the required prior to her M During intervented prior to her M Provider Not admitted for should have days before During follow p.m., SW-A policy on ens	d with art A," cal recovas ide notice Medica view or)-A state 8 was n-Cove a thera been a thera cove up in stated suring	age 3 a payment source of, and remained in the facility for ord was reviewed, however, no entified she had been provided s of Medicare non-coverage re services ending. 10/26/15, at 2:14 p.m. social ted there was no documented provided a Notice of Medicare erage (CMS-10123). R98 was apy stay at the facility, and given the denial notice two vered services ended. terview on 10/26/15, at 2:55 the facility did not have a the liability notices were given ey, "Just follow Medicare	F 15	administrator, of any emplor or other individuals who parter dentified the same of the policy of Lake Ridgeto insure residents are proving upon termination of the control	riticipated in the cussed or me. ge Care Center vided the enon-coverage vered services. liance, the tinto place; ts: ledicare other potential currences: blved with of the survey to a could ted were ensure recur: on 2 Nov 15 IDS Coordinator rocess for als using CMS eresource. ed at bi-weekly ming denials ely, followed by	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310	REET ADDRESS, CITY, STATE, ZIP CODE D LAKE BOULEVARD IFFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156 F 157 SS=D	(INJURY/DECLINE A facility must immerconsult with the resident involving to injury and has the properties of an accident involving to injury and has the properties of a significant of the resident in tervention; a significant of the clinical complication significantly (i.e., a existing form of treatment); or a decident from the \$483.12(a). The facility must also and, if known, the resident from the consequences of the resident from the same properties of the facility must also and, if known, the resident from the facility must also and, if known, the resident from the facility must also and, if known, the resident from the facility must also and, if known, the resident from the facility must also and the facility	IFY OF CHANGES	F 1.		MDS Coordinator will perform week audits to insure Medicare denials heen issued timely and scanned in resident medical record. Findings reported to the Quality Assurance meetings for the next two quarters. 5. Those responsible to maintain compliance will be: The Social Worker will be responsicompliance. Completion date for certification puronly is: 29 Dec 2015	ave to the will be ble for	12/29/15

T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		(X3) DATE SURVEY COMPLETED	
	245513	B. WING		10/2	26/2015
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
change in room or specified in §483. resident rights und regulations as spethis section. The facility must rethe address and plegal representative. This REQUIREMED by: Based on observative review, the facility doctor in a timely factor in a timely factor in a timely factor in a timely factor. Findings include: R45's annual MDS was cognitively intreceived insulin data. Lake Ridge Care (Report dated 4/20 subcutaneous oncombination and the subcutaneous oncombination). An Allina Health of indicated under "Yunits at bedtime. R45's Diabetic Add 4/30/15, indicated.	roommate assignment as 15(e)(2); or a change in ler Federal or State law or cified in paragraph (b)(1) of ecord and periodically update hone number of the resident's e or interested family member. ENT is not met as evidenced ation, interview and document failed to update the medical ashion for 1 of 1 resident (R45) by blood sugars requiring S dated 8/11/15, indicated she act, had diabetes mellitus and aily. Center signed Physician Order (15, indicated Lantus 37 units e in morning. Fice visit note dated 4/20/15, our Plan" back on lantus 37	F 15	F157-D Facility timely submits this response plan of correction pursuant to feder state law requirements. This response and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of the facility, the administrator, of any employees, agonor other individuals who participated drafting or who may be discussed of otherwise identified the same. It is the policy of Lake Ridge Care of the update the medical doctor in a time fashion. To assure continued compliance, the following plan has been put into plants. Regarding cited residents: Resident 118's medical record for page 12.	al and onse ssions does ency ed and ssion gents d in the or Center mely	
	PROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From p change in room or specified in §483. resident rights unce regulations as specifies and p legal representative This REQUIREME by: Based on observative review, the facility doctor in a timely f who developed low treatment. Findings include: R45's annual MDS was cognitively interectived insulin da Lake Ridge Care (Report dated 4/20) subcutaneous once An Allina Health of indicated under "Y units at bedtime. R45's Diabetic Adr 4/30/15, indicated morning with a sta	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: R45's annual MDS dated 8/11/15, indicated she was cognitively intact, had diabetes mellitus and received insulin daily. Lake Ridge Care Center signed Physician Order Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. An Allina Health office visit note dated 4/20/15, indicated under "Your Plan" back on lantus 37	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: R45's annual MDS dated 8/11/15, indicated she was cognitively intact, had diabetes mellitus and received insulin daily. Lake Ridge Care Center signed Physician Order Report dated 4/20/15, indicated Lantus 37 units subcutaneous once in morning. An Allina Health office visit note dated 4/20/15, indicated under "Your Plan" back on lantus 37 units at bedtime. R45's Diabetic Administration History 4/1/15, to 4/30/15, indicated Lantus 37 units once in morning with a start date of 4/17/15 and Lantus at	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) COntinued From page 5 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: F157-D Facility timely submits this responsion of a gradient or an agreement that a deficiency of exist of that a statement of a deficie vas correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the facility timely submits this responsion plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction pursuant to feder state law requirements. This responsion to the resident (R45) and plan of correction purs	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) COntinued From page 5 change in room or roommate assignment as specified in \$483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the medical doctor in a timely fashion for 1 of 1 resident (R45) who developed low blood sugars requiring treatment. Findings include: F157-D Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This not to be construed as an admission or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to update the medical doctor in a timely fashion. To assure continued compliance, the following plan has been put into place; 1. Regarding cited residents: Resident 118's medical record for pain management was reviewed on 28 Oct 15.

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/	26/2015
NAME OF F	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE DI	DOE 04DE 0ENTE	OF BUFFALO		310 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	Continued From p	age 6	F 15	7		
		ration History report indicated tus 37 units at HS from 4/20/15		since survey for review and adjus pain management.	tment of	
	The Buffalo Clinic 4/8/15, indicated a Lake Ridge care of	Telephone order report dated at 8:58 a.m. received call from center, had blood sugar of 67 r orders to call if below 80.		Resident 45's insulin/blood sugar were reviewed and the medical properties was updated multiple times since 15 to obtain orders for blood sugar parameter notification if symptom	rovider 30 Oct ır	
	dated 4/27/15, Dr. p.m., "Discussed 4/20/15 visit, had units at bedtime widaily MORNING Epatient has been idaily since the las sugars." Dr. Ande	inic Telephone order report Anderson indicated at 5:34 with (staff) by phone. As of written to return to Lantus 37 when it should have been once DOSE> Clarified with (staff) receiving lantus 37 units twice t visit with recent low blood rson then ordered Lantus 37 the morning as prior to hospital		2.Actions taken to identify other presidents having similar occurrent All residents have the potential for Residents with uncontrolled pain reviewed to ensure the physician aware of any changes and was up with the changes related to pain. Resident's with diagnosis of diabetave the potential for blood sugar outside of parameters. Resident's sugars were reviewed for past more and the process of the process of the potential for blood sugar outside of parameters.	ces: r pain. were was odated etes s s blood	
	on 4/22/15, at 7:4 only 52 mg/dl (mil the medical record	Center Vitals Report identified 4 a.m. R45 blood glucose was ligrams per deciliter). Review of d did not indicate the physician low blood glucose.		ensure the physician was aware of changes and was updated with the changes if needed. 3. Measures put in place to ensure deficient practice does not recur:	of e	
	a blood sugar was her breakfast mea did not indicate th low blood sugar.	s Note dated 4/25/15, indicated sonly 51 while R45 was eating al. Review of the medical record e physician was notified of the son Note dated 4/26/15, at 3:30		Education on notification to medic provider with condition change, di blood sugar management and pa management was completed by 1 15 for licensed nurses and TMAs. Morning IDT stand up meetings implemented on 30 Dec 15 to mo	abetic/ in 3 Dec	
	a.m. blood sugar record did not indi of the low blood g	of 51. Review of the medical cate the physician was notified		change in conditions and MD noti 4.Effective implementation of action be monitored by: Will audit ten residents with change in conditions and MD notions.	fication. ons will	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245513	B. WING _		10/26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 157	sugar) this morning had a BS of 38. The a.m." Resident Progress p.m. indicated "Res Lantus 37 units BID miscommunication appointment. Spoke HS dose has been continue the 37 unit. During interview 10. DON who stated she discrepancy and state a medication error. nurses should have they noted the orde since she was not cher low blood sugar. Although R45 had a if blood sugars were notify the physician. The facility's Chang Status policy dated.	ident had low BS (blood was sweating and shaky. she e physician was called at 8:44 Note dated 4/27/15, at 5:37 ident had been receiving (twice a day) since 4/20, written upon return from e with Dr. Anderson and the d/c'd (discontinued) and will its in AM." 1/26/15, at 9:30 a.m. with the re was not aware of the insuling ated she was unable to locate. The DON further stated the e called the physician when refor Lantus to be given at HS on that before and because of its. 1. In order to notify the physician is below 80, the facility did not of the three low blood sugars. 1. In Resident's Condition Or 7/14, directed "POLICY: It is	F 15	condition related to blood sugars ar with wound treatment to ensure me provider was updated and will also at ten MARs/TARs monthly for three n for pain effectiveness and blood sugoutside parameters to ensure media provider was updated. Facility will complete five audits of residents using the modified CMS CR Resident Interview Observation or modified CMS QIS Non-Interviewab Resident Observations weekly for the months. The data collected will be presented to the Quality Assessment Assurance Committee quarterly. At time the Quality Assessment & Assic Committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing is responsible compliance. Completion date for certification pure continued of the certification pure compliance.	dical audit nonths gars cal QIS DIS DIS At that urance gany to be
F 166 SS=D	resident, his or her representatives of comedical/mental con 483.10(f)(2) RIGHT RESOLVE GRIEVA	are, Inc. to promptly notify the Attending Physician, and changes in the resident's dition and/or status." TO PROMPT EFFORTS TO NCES ight to prompt efforts by the ievances the resident may	F 16	only is: 29 Dec 15	12/29/15
		se with respect to the behavior			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SI COMPLE	
		245513	B. WING _		10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP COD 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 166	of other residents. This REQUIREME by: Based on interview facility failed to atter grievance for 1 of the expressed concern bruising. Findings include: R45's annual Mining 8/11/15, indicated for required assistance and the concerning a complaint not take her seriou with sling placement wasn't taken seriou indicated it was given indicated it	NT is not met as evidenced wand document review, the empt to resolve an individual residents (R45) who had as over lift placement and rum Data Set (MDS) dated R45 was cognitively intact and e of two staff for transfers. I Action Form dated 8/12/15, "had complaints that when she to a nurse she feels they do sly Had concerns about lift and bruising [R45] felt she usly." The action form en to the DON. The form for of nursing (DON) response: ing well and gets d with illness. this writer did nat she down played the	F 16	F166-D Facility timely submits this resplan of correction pursuant to state law requirements. This rand plan of correction are not or an agreement that a deficie exist or that a statement of a cwas correctly cited or factually it's not to be construed as an against interest of the facility, administrator, of any employed or other individuals who partic drafting or who may be discus otherwise identified the same. It is the policy of Lake Ridge Coto resolve expressed grievance prompted by residents. To assure continued compliant following plan has been put into 1. Regarding cited residents: Weekly skin check completed Resident 45 on 28 Oct 15 with bruises noted. Interviewed Reson 23 Nov 15 to ensure transform occurring according to resident preferences. Transfer observates as facility does mechanical lift audits. 2. Actions taken to identify other	federal and response admissions incy does deficiency based and admission the es, agents ipated in the sed or Care Center es ce, the to place; on ano further esident 45 ers were at ation with periodically transfer	

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245513	B. WING		·····	10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	R45 stated the staf when she made a comonths ago when she reciling lift, the staff correctly and it slid causing a skin tear "irritated" because resident council", become about it." A facility Grievance 1/12/12, indicated, Care Center to proven the comportunity to voice facility." Further, the resident, their representations a contreatment, property encouraged to bring	ge 9 10/23/15, at 12:23 p.m. with f did not always listen to her concern. R45 stated a few she was being transferred from trap was not connected down on her right arm, and bruising. R45 was she "made a grievance in ut didn't "think anything was sand Complaints policy dated "It is the policy of Lake Ridge vide and environment that dignity, security, comfort and llowing residents and staff the extheir concerns to improve our expolicy indicated, "If a esentative, family member or incern with any aspect of care, or the facility; they are go that concern to the attention department manager."	F 1	166	residents having similar occurrence. The facility Vulnerable Adult log and Resident Council minutes from Oct were reviewed by Administrator. Interviewable residents will be inter by for potential VA concerns and non-interviewable resident's weekly checks will be viewed to determine injuries of unknown origin and followneeded by 13 Dec 15. 3. Measures put in place to ensure deficient practice does not recur: Grievance and Complaints policy a form was reviewed and revised by 15. Staff education on handling resident grievances and concerns and nursistaff education on transfer techniques mechanical lift will be completed or Dec 15. Administrator will review Resident Council minutes after Resident Council minutes after Resident Council meetings beginning in Nov 2015. 4. Effective implementation of action be monitored by: Facility will complete five audits of residents using the modified CMS (Resident Interview Observation or modified CMS QIS Non-Interviewal Resident Observations weekly for three months. Facility will complete five to Care Observations weekly for three months. Audits will be completed or grievance log and Resident Counciminutes monthly for three months. data collected on these audits will be presented to the Quality Assessme Assurance Committee quarterly. A	d cober viewed y skin w-up nd 30 Oct sident ing ues with a 13 sident ember ns will QIS ble hree NAR e on il The pe nt &	

Facility ID: 00714

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER (OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE
F 166	Continued From pa	ge 10	F 1	66	time the QA&A committee will make decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Administrator is responsible for compliance. Completion date for certification purely in the Administrator of the compliance of the complex of the c	g any i to be r	
F 167 SS=C	A resident has the r the most recent sur Federal or State sur correction in effect of the facility must make a mination and maccessible to reside their availability. This REQUIREMENT by: Based on observat	ight to examine the results of vey of the facility conducted by reyors and any plan of with respect to the facility. ake the results available for ust post in a place readily ents and must post a notice of out of the facility is not met as evidenced ion, interview and	F1	67	only is: 29 Dec 15		12/29/15
	documentation reviet the most recent State available for resider the potential to affect	ew, the facility failed to ensure te survey results were readily at and family review. This had at all 48 residents, visitors and review the information.			Facility timely submits this responsible plan of correction pursuant to feder state law requirements. This responsion and plan of correction are not admit or an agreement that a deficiency cexist or that a statement of a deficiency was correctly cited or factually base it's not to be construed as an admission.	ral and onse ssions does ency ed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` '		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 167	6:42 p.m. a clear pl the wall by the entry three ring binder. I survey results dated When interviewed of administrator stated worker (LSW)-A we	ge 11 ar of the facility on 10/19/15, at astic holder was attached to y way which contained a white the binder contained State of 10/24/13 (two years prior). an 10/26/15, at 5:30 p.m. the of the or the licensed social are responsible to update the 4 survey should have been	F 1	67	against interest of the facility, the administrator, of any employees, ac or other individuals who participated drafting or who may be discussed to otherwise identified the same. It is the policy of Lake Ridge Care of the post survey results so that they a available for residents and families review. To assure continued compliance, the following plan has been put into plant. 1. Regarding cited residents: The most recent survey results were posted on 26 Oct 15. 2. Actions taken to identify other post residents having similar occurrence. All residents had potential to be affect by alleged deficient practice. 3. Measures put in place to ensure deficient practice does not recur: Staff education addressing CMS requirements for posting of most resurvey results was completed by 13. 15. Survey book will be updated we new survey result by Administrator are available. 4. Effective implementation of action be monitored by: Facility receptionist will verify corresponded to the next Quality of the presented to the next Quality of the participated was completed to the next Quality of the presented to the next Quality of the presented to the next Quality of the participated was completed to the next Quality of the presented to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed to the next Quality of the participated was completed	center are to ne ace; re tential es: ected ecent 3 Dec vith as they ns will ct kly ol for		

-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE ((X3) DATE SURVEY COMPLETED			
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF CORRECTION		(X5) COMPLETION DATE
	Continued From page 12 483.13(c)(1)(ii)-(iii), (c)(2) - (4)			67	Assessment & Assurance Committee quarterly meeting. At that time, the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5. Those responsible to maintain compliance will be: The Administrator will be responsible for compliance. Completion date for certification purposes only is: 29 Dec 15		12/29/15
SS=D	been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness foother facility staff to or licensing authorit. The facility must en involving mistreatm including injuries of misappropriation of immediately to the atto other officials in a	t employ individuals who have abusing, neglecting, or abusing, neglecting, or as by a court of law; or have ad into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP (310 LAKE BOULEVARD BUFFALO, MN 55313	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 225	violations are thor prevent further poinvestigation is in The results of all i to the administrator representative and with State law (indicertification agencincident, and if the appropriate correct this REQUIREMED by: Based on intervie facility failed to enneglect and injurie immediately report agency and thorour residents (R45, Rallegations were residents (R45, Rallegations were residents (R45) annual Mini 8/11/15, indicated required assist of A Resident Councindicated that R45 brings a complain not take her serior	nave evidence that all alleged oughly investigated, and must tential abuse while the progress. Investigations must be reported or or his designated of to other officials in accordance cluding to the State survey and cry) within 5 working days of the evaluation and the evidence of the evaluation is verified crive action must be taken. ENT is not met as evidenced evidenced evidence allegations of abuse, as of unknown origin were ted to the administrator, state aughly investigated for 3 of 5 104 and R131) whose eviewed. In Data Set (MDS) dated she was cognitively intact and two staff with transfers. In Action Form dated 8/12/15, is "had complaints that when she it to a nurse she feels they do usly" R45 had "concerns about"	F2	F225-D Facility timely submits this plan of correction pursuant state law requirements. The and plan of correction are referred or an agreement that a defexist or that a statement of was correctly cited or facturit's not to be construed as against interest of the facility administrator, of any employor other individuals who partially or who may be discontinuously to the policy of Lake Ridges to report allegations of aburinjuries of unknown origin in	to federal and nis response not admissions iciency does a deficiency ally based and an admission ty, the oyees, agents rticipated in the cussed or ne. e Care Center se, neglect and mmediately to		
	she wasn't taken	ement and bruising," and, "felt seriously." The form identified it DON who responded, "Res		the administrator and state To assure continued complete.	o ,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/3	26/2015
NAME OF I	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/2	20,2010
					10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO			UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	[resident] was not paranoid/depresse her and that she d During interview 10 director of nursing of R45's concern to The DON stated Rever investigated or how the staff we nor was it reported the DON stated should bruising on R45. During interview 10 stated the staff does he voices a concerough. R45 stated transfer a few more the ceiling lift was caused it to slide of bruising on her arr "irritated" because out "owe, owe", but transfer. The staff despite her cries of Although R45 reposeing rough causing there was no indice state agency were an investigation be R104's admission he was cognitively	feeling well and gets and with illness did visit with own played the concern." 0/22/15, at 2:10 p.m. the (DON) stated she was aware out didn't feel it was of concern. 45's concern with the lift was including if there was bruising ere transferring the resident, at to the State agency. Further, we was was not aware of any of 23/15, at 12:23 p.m. R45 and always listen to her when ern that they (staff) can be alshe was being assisted to onthe prior, and the strap used by not attached correctly which down and cause a skin tear and m. R45 stated she was during the transfer, she yelled at the staff did not stop the proceeded to transfer her, af pain, stating "it's OK." orted during a transfer of staffing a skin tear and bruising atton the adminstrator and the immediately notifed, nor had been completed of the allegation. MDS dated 6/11/15, indicated intact and feels depressed.	F 2	225	1. Regarding cited residents: Incident for Resident 45 was submit 27 Nov 15 to OHFC. Investigation follow-up will be completed per region compliance. Resident 131 and Resident National Nationa	itted on and ulatory ident urvey. Itential es: Id ober viewed v skin w-up In on g staff Inseed ance on 28 es. stand nonitor rns.	
		dated 6/29/15, indicated that 4's room, "Writer got to the door			4.Effective implementation of action be monitored by:	ıs will	

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES				U	MR NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/2	26/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE DU	DOE OADE OENTED	OF BUFFALO		310 LAKE BOULEVARD		
LAKE KII	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	resident yelling and to hear what was al word "Fuck", and "y tone of voice. Write with nurse and saw (FM)-A was yelling asked if he wanted yes. FM-A was ask writer before he corthe time was holdin and was pointed to asked if his FM-A w stated yes. Writer a permission to do the Resident also state been physically abuthreatened to kill hir residents home. Reactually pushed him home to try to kill hir to show for it. Resiknow if he wanted F since he has been thelping him. Reside FM-A now had keys refusing to give thooresident, "you will hyou think you are go also stated FM-A had give that back. The to the state agency	ans loud voice that was not swearing. Writer was unable I being said but did her the our and Asshole" in an angry er immediately went into room resident's family member at resident. Resident was FM-A to leave. Resident said ed to leave several times by implied with leaving. FM-A at g up his phone that had a light wards resident. Resident was as video taping him. Resident asked resident if FM-A had his is and resident stated "no". If the past while at a sident stated that FM-A had in into a bonfire at residents in and he still had the scars dent express that he didn't fm-A back here at the facility the only one that has been ent also let writer know that is to his home, truck and was see back. FM-A told the ave to break into your house if ping back there". Resident as his laptop and refusing to a investigation was submitted on 7/01/15.	F 2:	Facility will complete five audits of residents using the modified CMS Resident Interview Observation or modified CMS QIS Non-Interviewa Resident Observations weekly for months. Facility will complete five Care Observations weekly for three months. Facility will complete five Education Audits of staff; audits will be completed on grievance log and Resident Council minutes monthly three months. Facility will monitor reports monthly for three months for timeliness of reporting to the Adminand state agency. The data collect these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time QA&A committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Administrator is responsible for compliance.	ble chree NAR e Abuse I also I for VAA or nistrator ted on e the g any g to be	
		ed and she did not know why it				

Although the incident occurred on 6/26/15, the

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245513	B. WING _	····	10	/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 225	facility did not report administrator and staffer the incident, of the state agency to investigation was not the state agency to the state agency to investigation was not the state agency to the state agenc	rt the incident to the state agency until two days on 6/29/2015. DS dated 2/25/15, indicated by cognitively intact and needed two with transfers. Export dated 4/5/15, indicated 1 had a, "exp. large discolored eft breast" which measured 10 8 cm in size. R131 was ability to continue to be ype of device, and R131 was ability to continue to be ype of device, and R131 was ince a hoyer lift for transfers. and the state agency was ident on 4/5/15 two days later on was submitted to the state 10 days after the incident ified the injury was from a control of the state and didn't ent late "maybe it was a urther, the DON stated and the location, the incident in the state and the location, the incident and the location, the incident in the state is and the location, the incident in the state in the location, the incident in the state in the location, the incident in the location, the incident in the state in the location, the incident in the location in the loc	F 22	5				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	following: Nursing a Director of Nursing administrator will be the above. Staff m Administrator if des violations and subsimmediately to the agencies as require (common entry poin (Minnesota Departr further indicated "A neglect and injuries promptly and thorous 483.13(c) DEVELO ABUSE/NEGLECT The facility must depolicies and proced mistreatment, negle and misappropriation. This REQUIREMED by: Based on interview facility failed to imput timely reporting and abuse, neglect, or in of 5 residents (R45 allegations were referred in the state of the	ediately to one of the supervisor, Nurse on Duty, or Social Worker. The enotified immediately by on of ay go immediately to the sired. Report all alleged tantiated incidents state agency and all other ed (oral report to CEP of the of the editory and electronically to MDH ment of Health)." The policy li reports of resident abuse, of unknown source shall be ughly investigated." P/IMPLMENT, ETC POLICIES evelop and implement written lares that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced or and document review, the lement their policy for the dinvestigation of allegations of injuries of unknown origin for 3, R104, and R131) whose	F2		e and al and nse ssions oes ency d and sion	12/29/15

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO			BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 226	report suspected/a abuse/neglect imm following: Nursing Director of Nursing administrator will be the above. Staff of Administrator if de violations and subsimmediately to the agencies as requir (common entry por (Minnesota Depart further indicated "Aneglect and injurie promptly and thore PA5's annual Mining M11/15, indicated required assist of the Aresident Councilindicated that R45 brings a complaint not take her serioulift with sling place she wasn't taken swas given to the Diresident] was not paranoid/depressed her and that she director of nursing of R45's concern to The DON stated Rever investigated or how the staff we nor was it reported	age 18 Illeged violations of resident nediately to one of the supervisor, Nurse on Duty, g, or Social Worker. The ne notified immediately by on of nay go immediately to the sired. Report all alleged stantiated incidents state agency and all other ned (oral report to CEP int) and electronically to MDH ment of Health)." The policy all reports of resident abuse, so f unknown source shall be oughly investigated." Thum Data Set (MDS) dated she was cognitively intact and two staff with transfers. I Action Form dated 8/12/15, "had complaints that when she to a nurse she feels they do asly" R45 had "concerns about ment and bruising," and, "felt eriously." The form identified it ON who responded, "Resfeeling well and gets ad with illness did visit with own played the concern." D/22/15, at 2:10 p.m. the (DON) stated she was aware out didn't feel it was of concern. "45's concern with the lift was including if there was bruising ere transferring the resident, it to the State agency. Further, we was was not aware of any	F 2	226	drafting or who may be discussed of otherwise identified the same. It is the policy of Lake Ridge Care of the develop and implement written pand procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of reproperty. To assure continued compliance, the following plan has been put into plants. 1. Regarding cited residents: Incident for Resident 45 was submited 27 Nov 15 to OHFC. Investigation follow-up will be completed per regulation. Resident 131 and Restonation 104 had VAA reports filed before sufficients having similar occurrence. The facility Vulnerable Adult log and Resident Council minutes from Octivere reviewed by Administrator. Interviewable residents will be interply for potential VA concerns and non-interviewable resident's weekly checks will be viewed to determine injuries of unknown origin and followneeded by 13 Dec 15. 3. Measures put in place to ensure deficient practice does not recur: Facility Vulnerable Adult policy was reviewed and revised and education VAA abuse prohibition and reporting requirements was completed with sand the facility guidelines for VAA	Center olicies f esident ne ce; itted on and ulatory ident urvey. tential es: d ober viewed v skin w-up	

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245513	B. WING			10/:	26/2015	
NAME OF PROVIDER OR SUPPLIEF	3		STREET ADDRE	SS, CITY, STATE, ZIP CODE			
LAKE DIDGE CARE CENTER	OF DUFFALO		310 LAKE BOU	JLEVARD			
LAKE RIDGE CARE CENTER	OF BUFFALO		BUFFALO, M	N 55313			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERS TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
stated the staff do she voices a concrough. R45 stated transfer a few monthe ceiling lift was caused it to slide of bruising on her an "irritated" because out "owe, owe", but ransfer. The staff despite her cries of Although R45 repobeing rough causist there was not inveadminstrator and inotified immediate. R104's admission he was cognitively. An Incident report on 6/26/15 in R10 and overheard a mesident yelling and to hear what was a word "Fuck", and tone of voice. Wriwith nurse and saff (FM)-A was yelling asked if he wanted yes. FM-A was as writer before he could the time was holding the state of the time was holding the state of t	0/23/15, at 12:23 p.m. R45 n't always listen to her when ern that they (staff) can be d she was being assisted to nths prior, and the strap used by not attached correctly which down and cause a skin tear and m. R45 stated she was during the transfer, she yelled at the staff did not stop the f proceeded to transfer her, of pain, stating "it's OK." orted during a transfer of staff ng a skin tear and bruising estigation done and the state agency were not	F 2	reporting education staff by 13 and conce Dec 15 to Facility ha up meetin for potent 4. Effective be monitor Facility wiresidents Resident modified (Resident months. I Question completed Council m Facility wifor three reporting agency. audits will Assessme quarterly. committee decision/r necessary continued 5. Those recompliance	ill complete five audits using the modified CM Interview Observation CMS QIS Non-Interview Observations weekly for Facility will complete fivervations weekly for the Facility will complete fivervations will make the Gent & Assurance Comment & Assurance Comment & Assurance Comment & Facility will make the Gent & Facility will be: The sponsible to maintain the will be:	censed ievance ed on 28 ome". DT stand to monitor neerns. It ions will of IS QIS or wable or three we NAR liree we Abuse dits will be Resident ee months. monthly of ad state these trulity mittee A ding any ling to be		

Facility ID: 00714

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	stated yes. Writer permission to do th Resident also state been physically abuthreatened to kill hi residents home. Reactually pushed hin home to try to kill hi to show for it. Resiknow if he wanted I since he has been helping him. Reside FM-A now had keys refusing to give tho resident, "you will hyou think you are galso stated FM-A higive that back. The to the state agency During interview 10 DON who stated thimmediately reported had been reported Although the incide facility did not reported administrator and safter the incident, or R131's quarterly Mishe was moderatel extensive assist of An Investigative Rethat on 4/3/15 R13	vas video taping him. Resident asked residnet if FM-A had his is and resident stated "no". In that (FM-A) has, in the past, usive to him and has also im in the past while at esident stated that FM-A had in into a bonfire at residents im, and he still had the scars ident express that he didn't FM-A back here at the facility the only one that has been ent also let writer know that is to his home, truck and was see back. FM-A told the eave to break into your house if oing back there". Resident as his laptop and refusing to be investigation was submitted on 7/01/15. 1/26/15, at 6:13 p.m. with the e incident should have been ent and she did not know why it late. 1. Introccurred on 6/26/15, the ret the incident to the state agency until two days in 6/29/2015. 1. DS dated 2/25/15, indicated y cognitively intact and needed	Fź	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
	245513	B. WING _			10/2	26/2015
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313	ODE		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD E	3E	(X5) COMPLETION DATE
reassessed for her transferred in this ty determined to requing the administrator a informed of the incition and investigation wagency on 4/13/15, occurred and identification mechanical lift. During interview 10 stated the investigation was secomputer glich". For because of the size needed to be reported to be reported. Although the injury facility failed to inforthe state agency two investigation was not the state agency two investigation was not schedules, and heather interests, assessinteract with membinside and outside about aspects of his are significant to the state aguificant to the significant to the significant to the significant to the significant to the state aguificant to the significant to the	8 cm in size. R131 was ability to continue to be ype of device, and R131 was ire a hoyer lift for transfers. and the state agency was ident on 4/5/15 two days later as submitted to the state 10 days after the incident ified the injury was from a 1/22/15, at 2:17 p.m. DON ation was sent late and didn't ent late "maybe it was a urther, the DON stated and area it was on, she felt it ted. was noted on 4/3/15, the rm the administrator and and to days later and the ot reported until 10 days later. ETERMINATION - RIGHT TO the right to choose activities, alth care consistent with his or assments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that	F 2:				12/29/15

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	facility failed to hon 3 residents (R73) refindings include: R73's admission M 10/1/15, indicated heeded assist of tw "very important" to which he was bathe R73's care plan data been admitted in Scidentify any prefere required with bathir Assistant Care Shebath on Thursday beath on Thursday buring interview 10 stated hospice is to week and the facility me two baths a we only received two bhave been here." The facilities Mill Covital List dated 9/21 identified on the bayone The week of 10/5 scheduled to receive bath documented a The week of 10/1 again scheduled to receive two baths documented to had one bath documented a The week of 10/1 scheduled to receive two baths documented to had one bath documented from the facility and from the facility and from the facility and facil	or bathing preferences for 1 of eviewed for choices. inimum Data Set (MDS) dated he was cognitively intact, to staff with bathing, and it was be able to chose the method in ed. Ited 9/25/15, identified he had eptember 2015, but did not nnces or assistance R73 hg. R73's undated Nursing het indicated he received a tub by an outside agency. If 10:02 a.m. R73 be giving me two baths a by is supposed to also be giving each. R73 then stated, "I have eaths from the facility since I reek Bridge Weekly Bath and 1/15 to 9/27/15, R73 was not th list. If 5 to 9/27/15, R73 was not th list.	F 2	242	Facility timely submits this responsible plan of correction pursuant to feder state law requirements. This responsion and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or the facility, the administrator, of any employees, as or other individuals who participated drafting or who may be discussed of otherwise identified the same. It is the policy of Lake Ridge Care of the thing of the policy of Lake Ridge Care of the honor resident's bathing preference. To assure continued compliance, the following plan has been put into plan. 1. Regarding cited residents: Resident 73 was interviewed for bath preference expressed on 21 Oct 15 plan and NAR guides updated to reference expressed on 21 Oct 15 plan and NAR guides updated to reference will be assisting with reside bathing preferences giving two bath week and facility providing two. 2. Actions taken to identify other portesidents having similar occurrence interviewable Residents were questusing a modified CMS Resident QII Interview tool to include bathing preferences and care plans to be util freeded. 3. Measures put in place to ensure	al and onse ssions does ency ed and ssion gents d in the or Centernces. Centernces. thing esident of Care effect eek; ent es per ential es: tioned S	

Facility ID: 00714

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	have received. During interview 10 assistant (NA)-F sta can, but added, "W we just can't get all baths have been m During interview 10 nurse (RN)-A stated his bath according to not documented on completed.	/23/15, at 9:15 a.m. nursing ated the staff do the best they e do not have a bath aide and of them done so some of the issed. That's all I can say." /23/15, at 9:21 a.m. registered to R73 should have received to his choice adding if it was the listing, it was not	F2	42	deficient practice does not recur: Facility revised process for interview residents about bathing/showering preferences upon admit and with comprehensive RAI reviews. Facility process and procedure for bathing reviewed and revised. Care staff and Activities educated on change of prowith bathing preferences and honor Resident choices by 13 Dec 15. 4. Effective implementation of actions be monitored by: Facility will complete five audits of residents using the modified CMS of Resident Interview Observation or modified CMS QIS Non-Interviewal Resident Observations and facility complete five NAR Care Observation weekly for three months. The data collected will be presented to the Quarterly meeting. At that time the Assessment & Assurance Committed quarterly meeting. At that time the Assessment & Assurance Committed and the decision/recommendation regarding any necessary follow-up and the decision of North Policy of Policy of North Policy of North Policy of North Policy of North Policy of Policy of Policy of Policy of Policy of Policy of Poli	ty was ad actice ring as will DIS ble will bns uality ee Quality ee will audits	
F 244 SS=E	483.15(c)(6) LISTE GRIEVANCE/RECO		F 2	44	compilation.		12/29/15
	must listen to the vi	family group exists, the facility ews and act upon the ommendations of residents					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	26/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ACTION OF CORD OF CROSS-REFERENCED TO THE ACTION OF CROSS-REF	SHOULD BE	(X5) COMPLETION DATE	
F 244	operational decision life in the facility. This REQUIREME by: Based on interview facility failed to proper resident council grawith inadequate stands affected 5 of the 48 R35 and R21) who council meetings from findings include: During the recertific council minutes we following: The resident council meetings for the facility of the facilit	NT is not met as evidenced w and document review, the vide timely follow-up to the oups grievance as concerned affing in the facility. This 3 residents (R27, R19, R45, regularly attended resident rom 7/28/15 to 9/29/15. Cation survey, the resident rere reviewed and identified the cil minutes dated 7/28/15, rsing R27, R19, R45, "All feel ough nursing help due to how eir call lights to be answered. Cotor (AD)] explained the cutting hours due to census short staffed." The minutes discussion, input from the opment of a plan to address 5's voiced concerns with p Resident Council Action 5, from the director of nursing response which identified, f the day and night when many esting assistance at the same ing to each one of them as a we are adequately staffed. Fare new and work a little slower	F2	,	o federal and a response of admissions iency does a deficiency ly based and a admission of the response or es. Care Center or resident and concerns of in the lance, the lance, the lance, the lance and will incil at the lance of follow up sutilizing to		

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DERICIENCIES AND PLAN OF CORRECTION 245513 NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO	CLIVILI	13 I OH MEDICAHE	A MEDICAID SETTICES			<u> </u>	<u>IVID IVO.</u>	0930-0391
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO X4) ID PRIEFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 244 Continued From page 25 were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistant help. They feel we do not have enough staff. Writer [AD] explained it is the nature of the business for nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/25/15, completed as a response by the DON indicated, "We continue to run ads & hire new employees continuously with retention too! Thank You [underlined several times with a picture of a smiley face drawn next to it]!" The resident council minutes dated 9/29/15, identified, "Council members are concerned about staffing. Writer [AD] explained staffing. [R21] had concern about waiting to go to his meal for too long. Writer explained about the requirement for a NAR's [nursing assistant, registered] to be able to sit with residents who need assist to eat and that this way likely the reason he had to wait." There was no evidence the repeated concerns regarding inadequate staffing at the facility were addressed by the management team.				, ,				
CALL DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS REFERENCE DO TO THE APPROPRIATE DEFICIENCY F 244 Continued From page 25 Were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council minutes acked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council minutes development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up was completed. Summary statement of concerns with state were need of more nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council minutes were reviewed by Administrator to identify additional resident complaints and ensured follow up was completed. 3.Measures put in place to ensure deficient practice does not recur: Facility Administrator reviewed and revised Grievance and Complaints policies, and education was provided to Department Heads on 23 Nov 15 on grievances. An update on the annual survey will be presented at the Resident Council meeting in December. 4.Effective implementation of actions will be monitored by: Administrator will review Resident Council minutes to ensure follow up has been completed following every Resident Council meeting for six months. The data collected will be presented to the Quality Assess			245513	B. WING		····	10/2	26/2015
Date Description Descrip	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PROPERTY TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	LAKE DU	DOE 04DE 0ENTED	05 DU5541 0		3	10 LAKE BOULEVARD		
F 244 Continued From page 25 were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistant help. They feel we do not have enough staff. Writer [AD] explained it is the nature of the business for nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/25/15, completed as a response by the DON indicated, "We continue to run ads & hire new employees continuously with retention too! Thank You [underlined several times with a picture of a smiley face drawn next to it]!" The resident council minutes dated 9/29/15, identified, "Council members are concerned about staffing. [R21] had concern about waiting to go to his meal for too long. Writer explained about the requirement for a NAR's [nursing assistant, registered] to be able to sit with residents who need assist to eat and that this way likely the reason he had to wait." There was no evidence the repeated concerns regarding inadequate staffing at the facility were addressed by the management team. F 244 the by December Resident Council where follow-up to resident concerns will be addressed. 2. Actions taken to identify other potential resident council minutes were reviewed by Administrator to identify addinal resident complaints and ensured follow up was completed. 3. Measures put in place to ensure deficient practice does not recur: Facility Administrator reviewed and revised Grievance and Complaints policies, and education was provided to Department Heads on 23 Nov 15 on gievances. An update on the annual survey will be presented at the Resident Council meeting in December. 4. Effective implementation of actions will be monitored by: Administrator viewed and revised Grievance and Completed following every Resident Council minutes to ensure	LAKE RII	DGE CARE CENTER	OF BUFFALO		В	BUFFALO, MN 55313		
were addressed, however R27, R21, R19 and R35 again stated, "All [residents] state we are need of more nurse assistant help. They feel we do not have enough staff. Writer [AD] explained it is the nature of the business for nurse assistants to be busy and to usually have another person waiting for assist while helping someone." The minutes lacked any further discussion, input from the residents, or development of a plan to address R27, R21, R19, R35, and R45's voiced concerns with staffing. A follow up Resident Council Action Form dated 8/25/15, completed as a response by the DON indicated, "We continue to run ads & hire new employees continuously with retention tool." Thank You [underlined several times with a picture of a smiley face drawn next to it]!" The resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council mensure by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes were reviewed by Administrator to identify additional resident council minutes dear reviewed by Administrator to identify additional resident council minutes w	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
During interview on 10/23/15, at 12:23 p.m. R45 stated she did not feel the concerns voiced during the council meetings were addressed, adding, "They are so short staffed here at the facility sometimes I have to wait 45 minutes for the staff to help me you see I am immobile and need help to get on the bed pan to have a BM [bowel movement] and when they are late, I can't wait so quarterly meeting by the Activity Director, and at that time, the QA&A committee will make the decision/recommendation regarding any necessary follow-up audits needing to be continued. 5.Those responsible to maintain compliance will be:	F 244	were addressed, he R35 again stated, "need of more nurse do not have enough is the nature of the to be busy and to u waiting for assist w minutes lacked any the residents, or de address R27, R21, concerns with staffic Council Action Forma response by the It to run ads & hire newith retention too! times with a picture it]!" The resident council about staffing. Write [R21] had concern for too long. Writer requirement for a Noregistered] to be about a reason he had to we the repeated concestaffing at the facility management team During interview on stated she did not for the council meeting. "They are so short sometimes I have to help me you see to get on the bed page of the state of the property of the council meeting."	All [residents] state we are assistant help. They feel we assistant state we another person hile helping someone." The further discussion, input from evelopment of a plan to R19, R35, and R45's voiced ng. A follow up Resident at dated 8/25/15, completed as DON indicated, "We continue the employees continuously Thank You [underlined several of a smiley face drawn next to did minutes dated 9/29/15, members are concerned the face at the face and the following assistant, allowed the sit with residents who and that this way likely the ait." There was no evidence the face and the face at the face and	F 2	244	the by December Resident Council follow-up to resident concerns will laddressed. 2. Actions taken to identify other poresidents having similar occurrence. The most recent Resident Council minutes were reviewed by Adminis identify additional resident complainensured follow up was completed. 3. Measures put in place to ensure deficient practice does not recur: Facility Administrator reviewed and revised Grievance and Complaints policies, and education was provided Department Heads on 23 Nov 15 or grievances. An update on the annusurvey will be presented at the Resident Council meeting in December. 4. Effective implementation of action be monitored by: Administrator will review Resident Council meeting for six months. The collected will be presented to the Council meeting by the Activity Diand at that time, the QA&A commit make the decision/recommendatio regarding any necessary follow-up needing to be continued. 5. Those responsible to maintain	tential es: trator to nts and ed to nual sident ns will Council een tt ne data Quality tee rector, tee will n	

pleasant for me."

compliance.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244 F 250 SS=G	who stated she is in council meetings. A complain about the problem everywher their concerns. I all and with so many rehave to wait." Although R27, R19 complaints of staffic continued at the 8/council meetings w plan being identified staffing. The facility Grievand dated 1/12/12, indice Ridge Care Center that enhances reside and peace of mind the opportunity to vour facility." The poresident, their represendent, their represendent, property encouraged to bring of the appropriate of 483.15(g)(1) PROV RELATED SOCIAL	10/23/15, at 9:30 a.m. the AD in charge of the resident AD stated, "The residents do staffing here and it's a e. I let the DON know about ways tell them we are trying esidents sometimes you just period of the providents and R21 had and on 7/28/15, their concerns I3/15 and 9/29/15 resident with no objective, measurable at to resolve there concerns of the ces and Complaints policy eated "it is the policy of Lake to provide and environment dent dignity, security, comfort by allowing residents and staff oice their concerns to improve oblicy further indicated "If a esentative, family member or incern with any aspect of care, or the facility; they are gothat concern to the attention department manager." ISION OF MEDICALLY SERVICE ovide medically-related social of maintain the highest I, mental, and psychosocial		244	Completion date for certification pu only is: 29 Dec 15	rposes	12/29/15
	This REQUIREMEN	NT is not met as evidenced					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	by: Based on observatoreview, the facility for related social service provided for 2 of 4 or reviewed for social actual, psychosocial expressed fear, inademonstrated signs concerns with her or Findings include: R29's quarterly Min 8/25/15, indicated tognitive impairment depression. R28's quarterly MD resident had severe had dementia with indicated R28 was sleeping, had little to herself, and had trous R28's Care Area As 6/12/15, indicated to antidepressant, for R28's care plan date depressed and was encourage express possible reasons for environmental/psycomedical conditions, management plan to sertraline (Zoloft)." had the potential for the resident and the potential for the province of the sertraline (Zoloft)."	tion, interview, and document ailed to ensure medically ces needs were identified and residents (R29 and R28) services. This resulted in all harm for R28, who bility to sleep, and sof distress regarding commate (R29). imum Data Set (MDS) dated the resident had severe not and had dementia with S dated 9/1/15, indicated the ecognitive impairment, and depression. The MDS depressed, had trouble or no energy, felt bad about	F 2	250	F250-G Facility timely submits this response plan of correction pursuant to feder state law requirements. This response and plan of correction are not admit or an agreement that a deficiency dexist or that a statement of a deficie was correctly cited or factually base it's not to be construed as an admis against interest of the facility, the administrator, of any employees, agor other individuals who participated drafting or who may be discussed of otherwise identified the same. It is the policy of Lake Ridge Care of the provide medically-related social services to attain or maintain the his practicable physical, mental and psychosocial well-being of each result of the provide medically related social services to attain or maintain the his practicable physical, mental and psychosocial well-being of each result of the care of the private room on 12 Nov 15. Resident 28 and family were intervity by Social Service and was moved to the private room on 12 Nov 15. Resident 28 and family were intervity by Social Service and was moved to the care plan. Resident 29 discharged to another on 23 Nov 15 to accommodate mer care needs. Family care conference held with Resident 56, spouse, social services.	al and onse ssions does ency ed and ssion gents d in the or Center ghest sident. The ide; ewed of a ent 28 y and dded facility mory	

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		В	BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	Continued From particles discuss behavioral as needed, and every psychological referon R28's progress not 10/25/15, indicated to R29, who is R28's progress not 10/25/15, indicated to R29, who is R28's consoled to make her with the second of	issues with the team members aluate the need for ral and evaluation. Ites reviewed from 7/09/15, to the following incidents related is roomate: esident] has been crying today. When she was little her mom watch the baby and she didn't so been say that her roommate stions and needs things and the says she is not getting se roommate is up a lot at ional as to where she is and of things. Resident is crying a of changing rooms. Writer and said she would see what	F 2			orate et dent e back od liabetic etes s, eyes, riewed d them up ic /15 and and will be o states care n active entinue	DATE
		ing with her roommate and			2.Actions taken to identify other polyresidents having similar occurrence Social Service reviewed care confe	es:	
	indicated, "Spoke of roommate last night with her roommate different room toda want to talk to her only the weather. We will be to the control of the contro	ress note from social services with res regarding incident with nt, res did remember arguing. She didn't say she wanted a say, but just said that she didn't roommate about just anything, Writer validated her feelings we she doesn't have to talk to			from past quarter to identify possible additional residents with room-mate concerns with no further action need. A diagnosis list was run from the falsoftware to identify other residents related diagnosis of Developmenta. Disability or related condition to det if any other residents met criteria for	le eded. cility with l termine	

Facility ID: 00714

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD	
LAKE R	IDGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 250	Continued From pa	ge 29	F 250		
	roommate about anything she didn't want to."			level II screening and need for activ treatment.	re
	roommate blocking Resident when in reside of room to mad On 9/5/15, resident "I'm loosing my mir on me; up at 1 am. room, did leave a nworker], 1 on 1 with this time." On 9/10/15, resident well last night statir her up asking who On 9/10/15, progreindicated, "Writer were stopped writer a stated 'I just saw or court! I have nothin my money! When money she was now was then coming of that little bitch! She night! Writer let resome one names. I roommate got close she just wants to so roommate. Writer direction but it took there separate way my room' and 'she screws him, she is eat- I don't even was	nt refusing to go into bed as roommate from entering. com, 'peeks' into roommates ke sure she is okay." Italked with writer and stated, ad, my roommate is rubbing off Talks of wanting a different nessage for SW [social a resident, and was effective at a resident, and was effective at the state of the same state of t		3.Measures put in place to ensure deficient practice does not recur: The facility implemented a daily IDT morning meeting with Social Worke attendance to discuss social service and/or room-mate concerns. Staff educated on overview of PASRR, reto resident altercation and intervent and resident non-compliance by 13 15. MDSs will be completed upon admission, quarterly and with significhange to include non-compliance arisk versus benefits. 4. Effective implementation of action be monitored by: Facility will complete five audits of residents using the modified CMS CResident Interview Observation or modified CMS QIS Non-Interviewab Resident Observations weekly time quarter. The data collected will be presented to the Quality Assessment Assurance Committee quarterly. At time the QA&A committee will make decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Social Services is responsible for compliance. Completion date for certification pur only is: 29 Dec 15	esident ions Dec icant and is will QIS ble s one int & that e the g any to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 250	and she stated she On 9/23/15, resided with the lady in her Resident stated sho one was given. On 9/23/15, "Writed computer res. station res was asked what neck- I don't sleep Res. stated 'I really any sleep with her relief. SS updated. On 10/6/15, social residents daughter concerns that resid who was after her a sleeping with all so just wanted to com [daughter] that no r that res has talked and they turn out to does not have men [daughter] stated s about it. She [daug the suicide comme call from the MD [n on Thursday and W she would talk to M Writer then spoke t and res has no plan at facility. No further today." On 10/07/15, "Res Res in hallway this	or does this to me all the time. Int stated she was up all night room yelling all night. The was, "Going crazy." One to runplugged cord from the property of the state of of the sta	F 2	50		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	<u>.</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE	
F 250	talking about how a kicked.' Res event into her room. Will A Lake Ridge Care form dated 10/8/15 to call R28's daugh number and he wo tomorrow. On 10/20/15, "Writ assistant registeres said she was going daughter to inform asked aides what he roommate didn't was said she didn't was the claim that room Aides said roomma make such a comma separated at this tibed." On 10/22/15, social with resident and con 10/20/15. Res roommate was goishe felt safe and with She stated her roomom that's all and sometimes. Asked her roommate duritimes res waved he yes its fine." On 10/23/15, social resident came to with the same the same the same the same than the same than the same the s	age 31 s going to be.' She was also another res 'needs her ass tually calmed down and went I continue to monitor." Center Fax Update/Order in indicated the MD attempted inter but had the wrong phone and call the social worker er informed by NAR (nursing do that Res claims roommate in the couther throat. Res called daughter of situation. Writer happened. Aides said and to go in room because Resist her there. Then Res made in mate said she'd cut her throat. The interest is and roommate in the wasn't even around Res to ment. Res and roommate in me. Res on her way back to the stated that she did not feel her ing to slit her throat, res stated in the pust gets that way it is a roommate. The interest is a roommate in the conversation and both in the conversation and both in the conversation and both in the service note indicated in the conversation and both in the conversation and that she needed in the conversation and th	F 250				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10.	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, 2 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 250	to get out of her roogets mad at her an Because she was slike hurting herself think so." On 10/23/15, "Resi saying 'I am getting resident, Oh it's rai out there. Residen rain. I'm not staying these awful people was resistant at firs go to the Vineyard. social services and put a Wanderguard. An Associated Clinical dated 8/17/15, indicand did not have surecommendations or when she voiced. A Geriatric Services dated 9/10/15, indicated 9/10/15, indicated 9/10/15, indicated 10/15, indicated 10/15	om because her roommate d shuts the door on her. So upset writer asked if she felt and res stated, "No, I don't dent was up at the front door out of here.' Writer told ning out. You don't want to go t replied, I don't care about the g here another night; live with here, I'm leaving. Resident of the total then writer got resident to Writer reported this info to nursing. At this time nursing I on resident." It of Psychology visit note cated R28 had depression, uicidal ideation. The were to use validation he appeared to have concerns, I concerns. So Of Minnesota physician visit cated, "The patient [R28] did any while complaining about hommate. I spoke with various of the patient has had problems of the patient for a private room."	F 2	50		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/:	26/2015
_	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 250	started to have troumonths ago, becaulate afternoon and more confused, annight. NA-T stated early morning and of bed crying statin roommate because uncomfortable." R. "Doesn't like being be "unsettled" abouwith R29. R28 had times a week of no because of R29, and were reported to so stated she had spodidn't want the resirather just wanted pictures and music space of the room R28's daughters had town, and she had change rooms because," between R28 stated, "Nothing ev R29 rooming toget." During interview 10 stated R28 and R2 [R29] is very forget minutes to the next room she is on and things and it upsets upset and will go on her family; she has never told me she suicide checks. W	NA)-T stated R28 and R29 ubles being roommates a few use R29 gets, "Crazy" in the night time. R29 becomes d is up hollering during the they have come to work in the R28 would be awake and out g she is fearful of her R29 was, "Making her 28 had expressed she, in that room," and continued to ut having to remain in the room d ongoing episodes several t sleeping well at night nd NA-T stated these concerns ocial worker (SW)-A, but SW-A oken to R28's family and they dent to change rooms, but the facility to add some to try to enhance the physical for R28. NA-T stated one of ad recently visited from out of expressed desire for R28 to ause she could, "See how it B and R29; however, NA-T er got done," about R28 and	F 2	50			

AND DUAN OF CORDECTION INDENTIFICATION NUMBER.		` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 250	charting. It would be separated." During interview 10 practical nurse (LP R29] fight a lot. I have and left messages almost ready to give nothing gets done of the frustrated, they done and about what wo be compatible with [R28] to move to reduce I felt her as be a good fit and the tells me she wants that she wants to ke "I don't think things occur." LPN-A statif with each other in During interview 10 stated, "I have never my life." R28 states present at the time Kleenex. R28 states room, I want a differ gals that work here wiping her tears with began rubbing her am so tired of this, mind to end my life have to put up with roommate (R29), "I p.m., R28 was still During interview on worker (SW)-A states."	de nice if they could be /26/15, at 4:13 p.m. licensed N)-A stated, "They [R28 and ave asked for a room change with the social worker. I'm e up; we keep charting and with it and the staff are very I't ask us about room changes ald work best, and who would who. I suggested for her om 126 when that was open not the other roommate would ey never moved her. [R28] to move [R28] says things Ill herself." LPN-A then stated, are charted as often as they ed R28 and R29 just, "Got into the hall." /26/15, at 4:23 p.m. R28 er been treated like this ever in ed to cry, and LPN-A (who was of interview) gave her a ed, "I have asked for a different rent room, and I have told the that!" R28 continued to cry her Kleenex. R28 then head and stated, "Oh my god I I have it in the back of my I am 86 years old, why do I this?" R28 stated her s nastier than nasty." At 4:33	F2	50		

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	discussed moving to rooms, but felt it wo either one of them. hallucinates and haman being in the roman around. SW-AR29 was keeping Fhad asked R28 aboshe had never had offered to move R2 however, her daughmove. SW-A stated have any private rorooms all have room they would rather whefore moving R28 filled out a waiver fowill wait until the resthe room, and there the near future. SV by the Associated Cowere to be seeing Fhowever, the last til there currently was scheduled. SW-Asthe Psychology clin months, because the good about keeping residents here." During interview 10 family member (FMR28's concern with resident does compost aware the physical private room for R25 in the roo	director of nursing (DON) had he residents to separate ould not be a benefit to move	F2	250			

room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE COMPLÉTION
F 250	stated a lot of the sibetween [R28] and was not aware whe with the situation be SW made the deter room assignments, am not sure why the them." DON stated comments from R2 made a comment a around her neck, ar that, she had a plant A facility policy addresocial services was provided. 483.20(k)(3)(ii) SEF PERSONS/PER CATTHE SERVICES provided by accordance with eacare.	/26/15, at 6:03 p.m. DON caff know there, "Is a clash [R29]." The DON stated she are the social worker was at etween the resident, and the amination regarding resident however, the DON stated, "I ey haven't moved one of she heard about suicidal 8, but was not aware R28 bout wanting a cord for and stated, "If she [R28] said but was not aware R28 bout wanting a cord for and stated, "If she [R28] said but was not	F 2	50	12/29/15
	review, the facility fadirected by the care reviewed for dental Findings include: R5's quarterly Minin	ion, interview and document ailed to provide oral cares as plan for 1 of 3 residents (R5) hygiene. num Data Set (MDS) dated R5 had intact cognition, and		F282-D Facility timely submits this respons plan of correction pursuant to feder state law requirements. This response and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficiency of the correctly cited or factually based it is not to be construed as an admit	ral and onse issions does ency ed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	1 .0/-	0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	required extensive hygiene, including to hygiene, including the had sevupper palate when R5's care plan date an, "Alteration in Aldressing, grooming care plan directed scare am [morning]. During interview on stated the care plan [staff] supposed to NA-F helped R5 ge offer or assist him to Further, NA-F state having his teeth bru doesn't develop or a teeth. When interviewed to stated R5 needs to complete oral cares offered his oral care offered his oral care happening."	on 10/20/15, at 9:16 a.m. R5 sliner chair in his room, and reral missing teeth on his asked about his oral health. d 7/14/15, identified R5 had DLs [activities of daily living] of and bathing". Further, the staff to assist R5 with, "Oral and pm [evening]" 10/23/15, at 12:55 p.m. NA-F is used to know "what we're do" for the residents care. It ready for the day, but did not o complete oral cares. Id she should make sure R5 is ashed and cleaned so R5 all disease, or loose additional on 10/23/15, at 1:04 p.m. RN-A be set up with assistance to s, and NA-F should have ses, "That's what should be	F 28	against interest of the facility, the administrator, of any employees, a or other individuals who participate drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care to provide oral cares as directed by plan of care. To assure continued compliance, t following plan has been put into plant 1. Regarding cited residents: Resident 5 was interviewed for preferences related to oral care on 15 and care plan/NAR Care guide updated. Oral care audits on Resi will be completed periodically as fadoes NAR Care Audits to ensure of cares delivered according to care plants having similar occurrences Residents identified as having pote be affected by area cited are resident who require assist with oral cares. 3. Measures put in place to ensure deficient practice does not recur: Education provided to care related 13 Dec 15 providing oral care and following resident care plans. Residents in Care plans and NAR care guides wupdated to reflect resident oral care needs. MDSs will be completed up admission, quarterly and with signic change to include oral care needs.	Center y the he ace; a 30 Oct dent 5 acility and colan. Attential es: ential to ents staff by ident will be enton ficant	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 38	F 28	4.Effective implementation of ac be monitored by: Facility will complete five audits residents using the modified CM Resident Interview Observation modified CMS QIS Non-Interview Resident Observations and facil complete five NAR Care Observ weekly for three months. The da collected will be presented to the Assessment & Assurance Commendately. At that time the Quality Assessment & Assurance Commendately and precessary followneeding any necessary followneeding to be continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible to maintain compliance. Completion date for certification	of S QIS or wable ty will ations ta e Quality nittee y nittee will tion up audits		
	FOR MI & MR	e) PASRR REQUIREMENTS dinate assessments with the	F 28	only is: 29 Dec 15		12/29/15	
	pre-admission scree	ening and resident review licaid in part 483, subpart C to a t					
	January 1, 1989, ar (i) Mental illness a	ust not admit, on or after ny new residents with: s defined in paragraph (m)(2) nless the State mental health nined, based on an					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 285	Continued From pa	age 39	F 28	5	
	independent physic performed by a per State mental health (A) That, because condition of the ind the level of services and (B) If the individual services, whether the specialized service (ii) Mental retardad (m)(2)(ii) of this secondation or deventable determined pring (A) That, because condition of the individual services, whether the specialized services and (B) If the individual services, whether the specialized services (ii) An individual is illness defined at § (ii) An individual is retarded if the individual is retarded if the individual is retarded if the individual is retarded in §483.102 related condition as	cal and mental evaluation from or entity other than the authority, prior to admission; se of the physical and mental ividual, the individual requires is provided by a nursing facility; all requires such level of the individual requires is for mental retardation. It ion, as defined in paragraph option, unless the State mental lopmental disability authority for to admission-to admission-to admission-to admission-to admission-to a mental ividual, the individual requires is provided by a nursing facility; and requires such level of the individual requires is for mental retardation. It is section: It is considered to have "mental dual has a serious mental than a se			
	by: Based on interview facility failed to ens Screening and Resevaluation was con	NT is not met as evidenced v and document review, the ure the Preadmission ident Review (PASRR) level 2 inpleted for 1 of 1 resident pass of moderate intellectual		F285-D Facility timely submits this respons plan of correction pursuant to feder state law requirements. This response and plan of correction are not adm	ral and onse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/-	-07-01-0	
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 285	disability. Findings include: R56's undated Residentified a diagnodisorder due to know R56's Initial Pre-Adresults based on in 9/9/15, by the Buff (SW)-C, identified intellectual disabiliti "Based on the information nursing home stay the criteria for DD needs to be referred evaluation. Please need for referral for made by Senior Linuary and English Senior Linuary and	sident Admission Record sis of other specified mental own physiological condition. dmission Screening (PAS) information submitted on allo Hospital social worker she had a diagnosis of mild ies. The screening noted, rmation provided for this it appears this person meets [developmental disability] and ad to the lead agency for further note final determination of the r further evaluation will be inkAge Line ®." Sheet dated 9/10/15, sent to orker (SW)-A from Central MN Senior LinkAge Line ®, noted warded to Wright County for the process for residents in and community based	F 28	or an agreement that a deficiency exist or that a statement of a deficiency as correctly cited or factually basit's not to be construed as an admagainst interest of the facility, the administrator, of any employees, a or other individuals who participated drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care to ensure PASRR evaluations are completed with a diagnosis of modintellectual disability. To assure continued compliance, following plan has been put into plants. The facility received a Level II Preadmission Screening from Irina Steuven, Wright County Social words to Steuven, Wright County Social words to dentify other poresidents having similar occurrence A diagnosis list was run from the facility at the residents related dx of Mental Retardation on Illness to determine if any other remet criteria for a level II screening. 3. Measures put in place to ensure deficient practice does not recur: Social Worker, or their designee, I been educated on PASRR and will reviewing Senior LinkAge Line PA for notation that resident may have Mental Illness. Social Worker or contains the social worker or contains t	iency sed and ission agents ed in the or Center derate the ace; a rker on otential ses: acility s with r Mental sidents . nas I be S forms e DD or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 285	referral was made level 2 evaluation. An additional PASF 9/11/15, was maint record. This screer registered nurse (Fagency identified of declared R56 did hevidence was pressible presence of DE identified, no referr a PASRR level 2 expension. SW-Astypically contacted evaluation was requipically contacted evaluation was requipically came out level 2 screening. Sknow if it was the follow-up if the courant asked whether R56 SW-A stated she dher medical record hospital told her R50 SW-A stated she dher medical record hospital told her R50 SW-A stated she dher medical record hospital told her R50 SW-A stated she dher medical record hospital told her R50 SW-D stated over a year and a follow-up if the courant asked whether R50 SW-D stated over a year and a follow-up if the courant asked whether R50 SW-D stated over a year and a follow-up if the required told her was seems like there we seems like ther	for completion of a PASRR RR level 1 screening dated ained as part of R56's medical ning was completed by RN)-F, with no associated in the forms. This screening have a DD/RC and presenting ent that may have indicated D/RC. Though conditions were all was made for completion of	F 28	will compare Senior LinkAge Li Level I and resident diagnosis f pertinent diagnosis that would i need for a Level II. Social Wor responsible to attach Preadmis Screening to resident electronic record. 4.Effective implementation of a be monitored by: The facility will audit five reside per month for three months, co Senior LinkAge Line PAS, PAS diagnosis list to determine if Pre-admission screening Level completed as required. The da collected will be presented to th Assessment & Assurance Com quarterly. At that time the Qual Assessment & Assurance Com make the decision/recommend regarding any necessary follow needing to be continued. 5.Those responsible to maintai compliance will be: The Social Worker is responsib compliance. Completion date for certification only is: 29 Dec 15	or Indicate the ker is sion common medical ctions will ctions will ctions will make and le Quality mittee ity mittee will ation cup audits	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 285	about R56's DD/RC there was some incompleted. The facility did not see identifying an actual the conversation prome psychological for R56 approximate further inquiry, SW-an intelligence quot notation of moderate Review of a Psychological testinate Nystrom & Associate Adult In Edition (WAIS-IV), resulting diagnosis disability. Although R56 had to screening completed the facility did not colarify the discrepant to determine if R56 screen completed.	guardianship. When asked diagnoses, SW-D stated lication of a learning disability, anything in her record I DD diagnosis. However, as ogressed, SW-D mentioned I testing that was completed ely six months prior. Upon D stated the testing identified itent (IQ) of 63 and included a re intellectual disability. Diogical Interpretive Report ailed assessment and g that was completed on R56 ciates, Ltd by licensed at the testing identified itent (IQ) of 63, with a of moderate intellectual wo separate PASRR and by two different individuals, ontact the county agency to ncy between the two PASRR, needed a level 2 PASRR	F 285			
F 309 SS=D	requested, but was	not provided. CARE/SERVICES FOR	F 309			12/29/15
	provide the necessor maintain the high	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED			
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	;	STREET ADDRESS, CITY, STATE, ZIP CODE B10 LAKE BOULEVARD BUFFALO, MN 55313	10/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 309	Continued From pa accordance with th and plan of care.	age 43 e comprehensive assessment	F 309			
	by: Based on observa review, the facility f assess and develo for 1 of 3 residents R118 voiced compl demonstrated distr dressing change. provide proper whe	tion, interview and document failed to comprehensively printerventions to reduce pain (R118) reviewed for pain. It laints of unmanaged pain, and ressing pain during a wound the facility also failed to relichair positioning for 1 of 1 to was leaning significantly to		F309-G Facility timely submits this response plan of correction pursuant to federal state law requirements. This response and plan of correction are not admissor an agreement that a deficiency doexist or that a statement of a deficient was correctly cited or factually based it's not to be construed as an admission against interest of the facility, the administrator, of any employees, ago or other individuals who participated drafting or who may be discussed or otherwise identified the same.	Il and ase sions bes ncy d and sion ents in the	
	identified diagnose disease (PVD), ost of the right lower exulcer of lower right infection, chronic p Neuralgia (nerve particular diagnosis). The admission Min 8/24/15, identified I and she required liactivities of daily lividentified R118 did medication, but recomedication and not interventions for particular particular diagnosis.	nimum Data Set (MDS) dated R118's cognition was intact mited assistance for most ring (ADLs). The MDS not receive scheduled pain seived as needed (PRN) pain		It is the policy of Lake Ridge Care C to ensure residents receive the necescare and services to attain or maintal highest practicable physical, mental psychosocial well-being. To assure continued compliance, the following plan has been put into place 1. Regarding cited residents: Resident 118 had comprehensive passessment completed, and medical provider was contacted multiple time changes in pain management. Resilies was hospitalized on 17 Nov 15 for wassessment and treatment. Upon refrom the hospital, a pain assessment	essary in the and ese; ain l es for dent ound eturn	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245513	B. WING			10/2	26/2015
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAVE DIDGE GADE GENTED OF	DUEEN		310	0 LAKE BOULEVARD		
LAKE RIDGE CARE CENTER OF	BUFFALO		Вι	JFFALO, MN 55313		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
her current pain was a to 10, numeric pain rat = the most intense pair was identified as frequiverbal description of the MDS identified she had ulcer at the time of the The Care Area Assess identified R118 needed due to weakness and costeoarthritis, but want herself as possible. The a stasis ulcer on her rigand continued to drain CAA identified R118, "I to neuropathy, osteoar right lower leg. States to [Ultram, an analgesic realized Also uses warm towels will continue to monitor [medical doctor] as need Although the MDS ider which made it difficult to day to day activity, the this area to determine appropriate for R118. The care plan dated 10 at risk for uncontrolled osteoarthritis and stasi extremity. The care plas state her pain was decanalgesic, or show nor pain. Interventions inclined	ay to day activity. A all pain rating scale identified in nine out of 10 (a zero (0) ting scale of 0 = no pain, 10 in imaginable). Her pain tent, but did not include a ne pain even though the done arterial or venous important management (CAA) dated 8/24/15, disassistance with all ADLs decreased mobility from ted to do as much for ne CAA identified R118 had ght leg that was infected large amounts of fluid. The ls complaining of pain due thritis, and stasis ulcer on that PRN Tramadol medication] relieves pain. It is and repositioning. Staffir for pain and update MD meded." The time of the pain regime was a pain related to its ulcer to her right lower and goal was for R118 to be reased with the use of an inverbal signs of decreased uded the following: aport pain levels PRN, per a service of the pain reverse of the pa	F 3	809	completed and Care Plan was update reflect resident pain goals and individualized interventions. Resident 57 had Occupational Therevaluation completed for positioning changes to plan of care with a follow Occupational Therapy evaluation for adaptations for comfort and skin. 2. Actions taken to identify other pot residents having similar occurrence All residents have the potential for pall residents with identified pain will their assessment and pain manage reviewed, to ensure they have propicontrol. All residents in wheelchairs observed for proper positioning. 3. Measures put in place to ensure deficient practice does not recur: Staff will be educated on pain identification and management and licensed nurses will be educated on Pain Observation by 13 Dec 15. Residents will be routinely assessed pain using the eMAR system. MDS be completed upon admission, qual and with significant changes to include comprehensive pain assessment. Staff will be educated on wheel changositioning and follow-up by 13 Dec Facility has implemented daily IDT up meetings starting 30 Dec 15 to repotential residents with pain and positioning concerns. 4. Effective implementation of action be monitored by:	rapy, g with w up or ential es: bain. have ment er pain will be d for 6s will rterly ude a Care ir 15. stand monitor I w/c	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING	····	10/:	26/2015
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRINCED TO THE APPRINCED TO THE APPRINCE OF THE APPRINCE	JLD BE	(X5) COMPLETION DATE
F 309	·Administer medic PRN, as ordered for Monitor R118 for reassessing her political conference of the American PRN, as ordered for the Monitor R118 for reassessing her political conference of the American Proposition of the American PR18 for related to an open She stated a routing been completed to pain she experient changes was exceover a 10." R118 signing her pain medicessing change to The ice packs, and subside almost, and like a grabbing pathrough the ceiling R118 was frequent and applying ice pher current pain les is tolerable." R118 an acceptable level On 10/22/15, at 9ther room, receiving from licensed pract LPN-F and R118 of a pain medication to treat liked to wait "for hed dressing change was LPN-F to return in dressing change and the Monitor PR18 of	ations to R118, routine and or pain. changes in comfort PRN, ain as needed. ort measures PRN, of t, cold, massage, diversional on and interview on 10/21/15, at omplained of unmanaged pain sore to her right, lower leg. The dressing change had just to her right leg and reported the ced during these dressing essive, stating her pain "hits estated if the nurses think of edication before and after the hey will, along with some ice. If the pain medication at times, "Will and then all of the sudden it is in that almost sends me in." During this conversation, thy rubbing her right, lower leg acks to the area. R118 stated wel was, "down to a five [5] it reported a pain rating of 5 was	F 309	Facility will complete five NAR Cobservations weekly and facility complete five audits of residents modified CMS QIS Resident Into Observation or modified CMS QIS Non-Interviewable Resident Obsevekly for three months. Ten chaill be done monthly for three management. The data cobe presented to the Quality Assessurance Committee quarterly time the Quality Assessment & A Committee will make the decision/recommendation regard necessary follow-up audits need continued. 5. Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	will using the erview IS ervations ert audits onths for llected will essment & At that Assurance ding any ing to be	

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO (X4) ID SUMMARY STATEMENT OF DEFICIENCIES SUFFALO, MN 55313 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILD)ING _		COIVI	PLETED
LAKE RIDGE CARE CENTER OF BUFFALO (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) ID PROVIDER'S PLAN OF CORRECTION (X6) ID PROVIDER'S PLAN OF CORRECTION			245513	B. WING	i		10/	26/2015
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 (X4) ID PROVIDER'S PLAN OF CORRECTION (NAME OF F	PROVIDER OR SUPPLIER						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (LAKE RI	DGE CARE CENTER	OF BUFFALO					
(747) 10		CLIMMA DV CTA	TEMENT OF DEFICIENCIES					0.60
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
rever quite cuts it when they start scraping, there's nothing (that could stop the pain)." At 10:11 a.m., LPN-F gathered supplies for R118's dressing change. While LPN-F was outside of the room, R118 was asked whether her pain medications were helping. She stated, "[It] never does," and rated her pain a seven, out of 0-10 pain scale. At 10:16 a.m., LPN-F returned to R118's resident room, completed her preparations for the dressing change and was about to begin the treatment when R118 asked, "Where's my ice pack?" LPN-F stated she had forgotten to bring the ice pack, but would bring it immediately upon completion of the dressing change. R118 said loudly and firmly, "No. You get that now." LPN-F said, "Okay, yes mam." LPN-F retrieved an ice pack and then began the dressing change. At 10:22 a.m., LPN-F removed the Kerlix (gauze bandage rolls) and ABD pad (a highly absorbent dressing used to provide padding and protection for large wounds). LPN-F then used a saline aerosol spray to slowly remove pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While LPN-F was removing the dressing and completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with itsuse paper that she held in her hand throughout the dressing change. During the dressing change R18 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118	F 309	never quite cuts it there's nothing [that 10:11 a.m., LPN-F of dressing change. We room, R118 was as medications were hooes," and rated he pain scale. At 10:16 R118's resident roo preparations for the about to begin the t "Where's my ice pat forgotten to bring th immediately upon of change. R118 said that now." LPN-F sa retrieved an ice pad dressing change. A the Kerlix (gauze ba highly absorbent dr padding and protect then used a saline a pieces of Silversorb slough, by wiping, r colored debris from LPN-F was removir completing debridm wincing, jerking and procedure. At 10:27 eyes, which she wip held in her hand thr During the dressing stop and pause sev and breathe before ready for LPN-F to change she would ther face, and choke	when they start scraping, to could stop the pain]." At gathered supplies for R118's While LPN-F was outside of the ked whether her pain lelping. She stated, "[It] never er pain a seven, out of 0-10 a.m. LPN-F returned to m, completed her edressing change and was reatment when R118 asked, ck?" LPN-F stated she had be ice pack, but would bring it completion of the dressing loudly and firmly, "No. You get aid, "Okay, yes mam." LPN-F ck and then began the to 10:22 a.m., LPN-F removed andage rolls) and ABD pad (a lessing used to provide tion for large wounds). LPN-F aerosol spray to slowly remove to (an absorptive dressing) and olling and picking off the black R118's open wound. While and the dressing and then to f the wound R118 was a pulling away throughout the read with tissue paper that she roughout the dressing change. I change R118 made LPN-F weral times, to take a breath continuing. When R118 was proceed with the dressing take a deep breath, grimacing and with emotional tone to her	F3	309			

stated, "Okay, it's starting to burn." LPN-F asked

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10	/26/2015	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	R118 if she had not medication to beg I'm just gonna have the pain." As soon R118 immediately right lower leg and stockinet and griph allowing R118 to be dressing change with time to admin medication (oxyco pain medication) to the medication, and gripper stocks, an R118 rated her padressing change, because I'm abour pain." At 10:43 a.r. pack, firmly to her her pain as an eigwas starting to deask R118 to rate her the dressing change was starting to deask R118 to rate her pain as an eigwas starting to deask R118 to rate her pain as an eigwas starting to deask R118 to rate her pain as an eigwas starting to deask R118 to rate her pain as an eigwas starting to deask R118 to rate her pain gon derived R118's dead indicators she obstreaction during her reported R118's pain mana offering Ultram firswas not effective. have ice at any tin pain management time. She was no physician was, for	age 47 bt left enough time for her pain in working. R118 replied, "No, re to get something stronger for as LPN-F applied the Kerlix, applied the ice pack to her I made LPN-F stop before the per socks were applied, breathe, and rest after the vas completed. LPN-F used ister another PRN pain idone 5mg 1 tablet, narcotic or R118. LPN-F administered oplied R118's stockinet and dat 10:37 a.m., left the room. In as a nine, and during the stated, "It's gotta hit 15, it ready to pass out from the m., R118 was still holding the ice leg. At 10:45 a.m., R118 rated th (8) and stated her pain level cline at this time. LPN-F did not her pain before, during or after ge even though LPN-F applied and non-verbal pain herved, which was a typical or dressing changes. LPN-F octor and nurse practitioner se symptoms. LPN-F stated gement regimen consisted of st, then oxycodone if the Ultram LPN-F added, she could also ne and this has been the same of regimen for R118 for some to sure what the rational of the not making further changes to the regimen of the part of the p	F3	09			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 309	trys to give her (R1 the dressing, so sh and "get her bearin when she is ready. R118's current phys directed the followin management regim ·Wound treatment lower extremity- cle cover with ABD pad daily and PRN. ·Gabapentin 300 m peripheral neuropa ·Ultram 50 mg, eve chronic pain syndre ·Oxycodone 5 mg, not relieved by Ultra Review of R118's pa 8/17/15, to 10/26/1 R118's New Patien Examination, comp (MD)-A and dated 9 osteoarthritis affect hip, with residual pa arthroplasties. The her pain. On 8/24/15, nurse had complaints of pa with dressing chang On 9/10/15, NP-A r R118's right lower I treatments. NP-A n will add oxycodone pain." On 9/23/15, a Wou History and Physica	18) time when she removed e (R118) can take a breath gs" and will then continue sician orders dated 10/26/15, ng wound treatment and pain nen: to stasis ulceration on right canse wound, apply Silversorb, d and Kerlix, change dressing nilligrams (mg), twice daily for thy/ polyneuropathy. The polyneuropathy for pain am, for chronic pain syndrome. The every four hours PRN for pain am, for chronic pain syndrome. The hysician progress notes from 5, identified the following: the History and Physical bleted by medical doctor 19/3/15, noted she had ain post knees, shoulder and ain post knee and hip report did not further address practitioner (NP)-A noted R118 pain to her right lower extremity	F3	09			

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED	
26/2015	
(X5) COMPLETION DATE	

The September 2015 EMAR identified R118 took

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	;	STREET ADDRESS, CITY, STATE, ZIP CODE 810 LAKE BOULEVARD BUFFALO, MN 55313	,	, _ 0 1 0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	She took 68 doses effective 42 of 68 of 14 of 68; not effective was not identified for R118 had 35 doses September 2015, which was not opportunities; slip other which was not opportunities. The October 2015 administered 100 dright, lower extremit doses of Ultram 50 of 49 opportunities; and not effective 6. R118 had 51 doses October 2015 which opportunities; slight effective 5 out of 51 identified, 1 out of 51	s of PRN pain medication. of Ultram 50mg, which were pportunities; slightly effective ve 2 of 68, and other, which or 1 of 68 opportunities. of PRN oxycodone 5mg in which was effective 14 out of ightly effective 3 out of 35; and t identified 3 out of 35, EMAR identified R118 was oses of pain medication for ty leg pain. She took 49 mg, which was effective 18 out slightly effective 17 out of 49; out of 49 opportunities. of PRN oxycodone 5mg, in h was effective 34 out of 51 ty effective 11 out of 51; not l and other, which was not	F 309				

_	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/	26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 309	8/17/15, through 10 of pain for R118: On 8/24/15, at 10:1 "Changed dressing hour later Resident Writer asked if a patoo much and it need asked for it to be tall dressing cleaned Bacitracin with non-with ABD and wrapp not have any further that she receive softhat won't burn." On 8/27/15, at 1:09 rates pain 8/10;p 'burns' refused to hole being sent to updat doctor]." On 8/27/15, at 10:2 dressing changed macerated et [and] claims the wound swashing wound. Recon her D/T [due to] On 9/6/15, at 10:48 c/o pain in RLE drequest; cool cloth has been elevated; when may have pron 9/7/15, at 1:39 proted, "[R118] refus fear that it would stall leaving it open to aid On 9/8/15, 2:28 p.m. the on call MD/NP aresident's wound or	ursing progress notes from 1/26/15, identified complaints 8 p.m. LPN-G noted, on lower right leg About an had c/o a 'burning pain.' tin pill would help or if it was eded to be taken off? Resident ken off. Writer took off wound and only applied estick dressing then covered ped with Kerlix. Resident has r c/o pain but is requesting mething else on the wound a.m. LPN-D noted, "[R118] er resident alginate dressing ave on skin;communication e PMD [primary medical 3 a.m. LPN-F noted, "Leg . Area continues to be red, tender to the touch Resident pray hurts her when use for esident refused it to be used reported pain." p.m. LPN-D noted, "[R118] ressing removed per [R118's] applied with some relief; leg will reassess in one hour in pain medication." D.m. registered nurse (RN)-C sed to have dressing put on in eart hurting again [R118] is	F3	309			

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PF		(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245513	B. WING			10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RII	OGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	pain to RLE. [R118] prn pain medication call physician said Tylenol. Will adminimonitor." On 9/13/15, at 12:2 [R118] does c/o paid change PRN pain at this time." On 9/19/15, at 1:12 c/o 7/10 pain right leaders with prn Tradressing changed by On 9/23/15, 10:39 pmedicated as directed as directed to be understood on 10/8/15, at 2:09 continues to c/o paid changes et PRN payment 2 different PF closer together. Resultance and leg measure macerated with son change when NP won 10/12/15, 2:27 pcontinues to c/o paid Resident makes really continues to be dressing changes." On 10/15/15, at 12: "Treatment complete treatment is being of med prior to tx [treat it hurts when it is op On 10/17/15, at 11:	m. LPN-C noted, "[R118] c/o is unable to have any more of for another 2 [two] hours. On it to use standing order of ster Tylenol and continue to 5 p.m. LPN-B noted, " on during a.m. dressing is medication given x [times] 2 a.m. LPN- D noted, "[R118] ower extremity; somewhat amadol, ice, and oxycodone; by DON [director of nursing]." o.m. LPN-I noted, "[R118 was] ted for leg pain. [R118] states, and drainage is left on my leg." p.m. LPN-F noted, "[R118] in et request frequent dressing in meds which were helpful RN pain meds were given sident has been seen by NP. res 16 cm x 10 cm draining et ne greenish color at first has in room." o.m. LPN-F noted, "[R118] in. PRN pain meds given x 2. quests for dressing changes. In a painful et macerated during the completed, had received pain atment] being done. States that	F3	309			

pack and PRN pain medication."

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 309	nursing assistant (Ner legs and she had spoken to recently as 10/14/1 satisfaction with he ugs and she to R118 complained of see if she could be NA-A stated the pa "somewhat effective [effective]." During interview on registered nurse (Five) was mainly in her rian open area. RN-I improving, but was review of the EMAF rating was typically prior to receipt of hereported R118's ph Thursday and was ensure her pain masufficiently effective notation of the physicommenting on her progress notes, on had attended a wor after 9/23/15, becardid not want to go the shead spoken to recently as 10/14/1 satisfaction with he upon inquiry as to pain, RN-H replied that she was aware dressing changes,	and 10/26/15, at 10:42 a.m. NA)-A stated, R118 has pain in ad seen her "pretty upset and d has seen R118 in pain ned of pain to her almost daily. Id the facility nurses when and and/or appeared in pain, to given any pain medication. In medications seemed e, [but] never 100% 10/26/15, at 2:32 p.m. RN)-H reported R118's pain and and long time. Upon R, RN-H reported R118's pain around an 8 (0-10 pain scale) er PRN pain medications. She ysician was at the facility every responsible for monitoring to an agement regimen was e. RN-H stated the most recent sician/ nurse practitioner repain was the physician's 10/8/15. RN-H reported R118 and clinic, but stopped going use she was very upset and here anymore. RN-H stated R118 about her pain, as 5, and she had indicated repain management regimen. R118's acceptable level of she was unsure. RN-H stated e R118 had significant pain with but believed the current pain men was effective for her. She	F 3	09			

_	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
F 309	result in some, inever changes. However, dressing change or knowledge of R118 extreme. RN-H states he is having that nuch pain." RN-H concerns for R118, NAs. RN-H stated, have updated the punmanaged pain, a looked at getting armedication. RN-H spack was typical, he were seeing, then to management of he R118's pain should confirmed the facilities their sole pain as completed on a quantification and asked throughout the dressing change. Tooked at R118 and distracting her during DON stated she fel effective as they care the state of th	R118's wound was going to ritable pain during dressing when told of the observed in 10/22/15, RN-H denied having reactions to that red, "If she [R118] is saying much pain, she is having that denied any reports of pain from the facility nurses or she expected staff would hysician if/when they identified increase in R118's pain stated R118's use of the ice owever, "If that was what we hat would not be a sufficient or pain." RN-H confirmed, have been reassessed. RN-H by used section J of the MDS seessment, which was only	F3	309			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245513	B. WING		10	10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIF 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	they were present never seen R118 of and upon discussichange (10/22/20) that kind of resport had completed or changes. The DOI discomfort with this if R118 had demond as identified in the expected the nursemedical record and getting some differ her. Although R118, had progress notes the had nurses and nurs	were much more painful than y. The DON stated she had cry during a dressing change on of the observed dressing (15), she denied having seen ase from R118 any time she observed her dressing N stated she expected some is type of dressing change, but instrated significant signs of pain 10/22/15 observation, she is to document this in the id see what they could do about rent analgesic medications for a stasis ulcer, had frequent at identified significant pain, and ursing assistants who observed in the day. R118 only received are during her dressing changes ing the day. R118 only received are prior to her dressing change o/22/2015, and then received iter the dressing change was hough R118 voiced complaints in, and demonstrated aring a wound dressing change. Comprehensively assess and ropriate pain management sist in reducing her pain.	F3	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIF 310 LAKE BOULEVARD BUFFALO, MN 55313	² CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 309	The policy did not firmanagement during policies regarding policies regarding policies regarding policies regarding policies with EEL CHAIR PORTO R57's quarterly MDR57 used a wheeled extensive assistance (ADLs). R57's care 4/21/15, indicated slimited range of molegal policies and occup. A Resident Progress indicated "pillow give due to resident lear Progress Note date up in wheel chair airight." During and observating in wheel chair airight." During and observating in a be sleeping with he arm, leaning to her a.m., R57 was agaichair, leaning to he 8:58 a.m., R57 was wheel chair with he table. On 10/23/15, observed sitting in right side with her has placed on the chair. Although R55	lgesic medication as ordered. urther address pain g dressing changes. Facility bain management with vere requested, but no vere provided.	F 3	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245513	B. WING		10	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	During and interview NA-B stated R57 retime, that's why we further stated R57 side, not sure why side, not sure why soccupational therapy R57 was recently gher wheel chair. Or referral "about a mepicked up for ongois size was appropriated fatigued. During an interview NA-T stated, R57 is get her up for breatin her wheel chair. to lean a little but he for the past few we During an interview LPN-H stated, som getting her (R57) to will place a pillow uncomfortable posithat." LPN-H furthe her second chair, a lateral supports or at high risk for falling she is always leaning stated, R57 had be therapy for position been re-evaluated.	w on 10/23/15, at 11:32 a.m., efuses to lay down a lot of the put pillow by her head. NA-B 'has always leaned to the right that is." on 10/23/15, at 11:48 a.m., by assistant (OTA)-J stated iven a right lateral support for TA-J stated R57 was seen for a conth or so ago," but was not ng therapy. He felt R57's chair the but that (R57) was more on 10/26/15, at 1:53 p.m., is like that "all the time," they kfast and then she falls asleep NA-T further stated, she used er leaning has been going on	F3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245513	B. WING		10/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 312 SS=E	they had received a because of her lear supports. They als down if tired and list negative outcomes the time of the refe lateral support was amount of assistant and be able to proport. And OTA-J fulleaning that bad who will current positioning have been referred evaluation. A policy addressing requested, but was 483.25(a)(3) ADL CODEPENDENT RESIDERT	pist (OT)-K and OTA-J stated, a referral in September for R57 ning and gave her a lateral or recommended she (R57) liested the potential for several of a sore back, and neck. At real in September 2015, the providing R57 with the ce she needed to sit up right belief herself in her wheel chair. In the stated, R57 was "never nen we saw her" and that her was a change and she should back to therapy for an appositioning for residents was not provided. CARE PROVIDED FOR IDENTS	F 309		12/29/15
	daily living receives maintain good nutri and oral hygiene. This REQUIREMED by: Based on observareview, the facility frompleted for 2 of completed for 2 of assistance with toil residents (R126) residents (R126) residents	nable to carry out activities of the necessary services to tion, grooming, and personal of the necessary services to tion, grooming, and personal of the necessary services to tion, grooming, and personal of the necessary services and document ailed to ensure nail care was 5 residents (R5, R64), bathing 5 residents (R45, R19), and the necessary services of the necessary of the necessary of the necessary services of the necessary services and the necessary services and the necessary services and personal necessary services to the nece		F312-E Facility timely submits this response plan of correction pursuant to federa state law requirements. This response and plan of correction are not admissor an agreement that a deficiency dexist or that a statement of a deficiency was correctly cited or factually base	al and nse ssions oes ncy

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD		
		0. 20.17.20		E	BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	9/15/15, identified in required extensive complete her personance complete her personance personanc	RE: mum Data Set (MDS) dated R5 had intact cognition, and assistance from staff to onal hygiene. on 10/20/15, at 9:16 a.m. R5 cliner chair in his room. R5 gernails on both hands with a ance underneath several of the e was diabetic so "not them", but added his e to have shorter nails. On .m. R5 continued to have long, both hands. on 10/22/15, at 1:53 p.m. NA)-T stated R5 seldom esistance from staff, and nail expleted on residents scheduled p.m. NA-T observed R5's ey were too long, and "not very Further, NA-T stated they ey preference of R5 to have ls and they should be trimmed.	F3	312	it's not to be construed as an admis against interest of the facility, the administrator, of any employees, as or other individuals who participated drafting or who may be discussed to otherwise identified the same. It is the policy of Lake Ridge Care to provide the necessary services to maintain good nutrition, grooming a personal and oral hygiene. To assure continued compliance, the following plan has been put into planta. 1. Regarding cited residents: On 22 Oct 15, after Resident 5 refunds was able to trim resident's nate Resident 5 and Resident 64 nails was audited and were cleaned and trimple and was offered alternative options chux, disposable products etc. Resistated it was his desire to continue newspaper to enhance independer with improved health condition he of feel this would be needed any long. Resident stated with condition	gents d in the or Center o and ne ace; ased, ails. vere med. t 126 of sident use of ace, but did not er.	
	licensed practical n long, dirty fingernai cut." Further, LPN- on nursing staff for	10/22/15, at 2:33 p.m. Jurse (LPN)-A observed R5's Is and stated "they need to be A stated R5 was dependent his nail care, and his nails rimmed and cleaned on his			improvement he is now using commat bedside for most all toileting nee Resident and NAR Care Guide upon reflect residents preferences for maintaining as much independence possible. Resident 19 received their bath on	ds. lated to e as	
	When interviewed	on 10/23/15, at 11:23 a.m.			15. Resident 45 received their bath		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE : COMPL	
		245513	B. WING			10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
		0= DUFF44 0		31	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		В	UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 60	F 3	312			
	registered nurse (R assistance to comp should have been compared to the company of the company o	egistered nurse (RN)-A stated R5 required ssistance to complete his nail care, and his nails nould have been cleaned and trimmed, "[They] nould be taken care of when they get their bath one." Oct 15. Resident 19 and Resident be interviewed for bathing properties. 13 Dec 15. 2.Actions taken to identify or residents having similar occ.		2.Actions taken to identify other po	ces by tential		
	R64 had moderate	S dated 9/15/15, identified cognitive impairment, and			All resident's nails were observed t ensure nails were trimmed.	0	
	complete his persor	assistance from staff to nal hygiene. on 10/20/15, at 9:36 a.m. R64			Random audits on incontinent residensure timely assistance with toilet based on assessed needs.		
	was seated in a sta R64 had visibly long having a dark color several nails. R64	ndard wheelchair in his room. g fingernails with several nails ed substance underneath stated he preferred to have			Residents were interviewed using a modified CMS Resident QIS Intervito include bathing preferences. Au completed to ensure residents received to be the strip of the bathing.	iew tool dits	
	On 10/22/15, at 9:0 wheelchair outside	dding they "could use a clip." 4 a.m. R64 was seated in his his room, and continued to ernails on both hands.			timely bathing. 3.Measures put in place to ensure deficient practice does not recur: Care staff education completed and	d	
	NA-T stated R64 has assistance to their lobserved R64's nai	on 10/22/15, at 1:53 p.m. ad never refused cares or staff knowledge. At 2:03 p.m. NA-T is and stated they were "very e cleaned and trimmed.			training content included completin resident cares (nail care, toileting, a bathing) and following resident care Facility revised process for intervier residents about bathing/showering	and e plan.	
	observed R64's nai	10/22/15, at 2:33 p.m. LPN-A ls and stated they should have rimmed on his bath day.			preferences upon admit and with comprehensive RAI reviews. Facil process and procedure for bathing review and revised. Care staff and Activities educated on change of pro-	was	
	stated R64 had no	10/23/15, at 11:23 a.m. RN-A desired preference to have s and they should have been ed on his bath day.			with bathing preferences and hono Resident Choices by 13 Dec 15. 4.Effective implementation of action	ring	
		rooming and nail care was			be monitored by: Facility will complete five audits of residents using the modified CMS		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	had intact cognition assistance from stated she does not bath because of the Further, R45 stated consistently makes like to have her bath Facility Lakeside O 9/14/15 to 10/21/15 were constructed be week, and staff we which day they reconame on the form a completed. R45's records, however fistaff initials identifies he received bathin record initials were When interviewed NA-C stated R45 ethey were sometim of staff to complete. During interview or stated she was not her baths as scheduler. Further were surprise me." Further stated she was not her baths as scheduler.	dated 8/11/15, identified R45 n, and required physical aff to complete her bathing. 10/22/15, at 1:46 p.m. R45 of always receive her schedule efacility being short staffed. If the distribution of the receiving her bath is her "angry", and she would thing completed. The records dated of were reviewed. The records by identifying the days of the re to identify a resident on eived their bath by writing their and initialing next to it when name was identified on the or three weeks there were no ed next to her name to identifying. The spaces provided to left blank. On 10/22/15, at 1:36 p.m. enjoyed her showers, but added es not completed due to a lack	F3	12	Resident Interview Observation or modified CMS QIS Non-Interviewal Resident Observations and facility complete five NAR Care Observation weekly for three months. 10 timing for toileting will be completed each for three months. 10 bathing audits be completed monthly for three months three months are completed monthly for three months are completed will be presented Quality Assurance and Assessment Committee quarterly. At that time the Quality Assurance and Assessment Committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing is responsite compliance.	will ons audits month s will onths. d to the t the t g any g to be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245513	B. WING			10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313	, CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 312	R19's quarterly MD R19 had intact cogn from at least two st During interview on stated she was sup a week, but had to because there was facility. Further, R1 receive all of her scimportant to her. A facility Mill Creek List dated 8/3/15 to scheduled for a bat was constructed by week, and staff wer which day they recename on the form a completed. Howev baths for four of six according to the recename have been m staff available to constated her expectat bathing as required A facility policy on both the constant of the con	S dated 9/29/15, identified nition, and required assistance aff to complete her bathing. 10/22/15, at 2:11 p.m. R19 posed to receive a bath twice go without her baths at times "not hear enough" staff at the 9 stated she wanted to sheduled baths as it was "very" Bridge Weekly Bath and Vital 10/21/15, identified R19 was h twice a week. The listing identifying the days of the eto identify a resident on eived their bath by writing their and initialing next to it when er, R19 was not provided her teen scheduled times cord. on 10/22/15, at 1:36 p.m. njoys her baths, but added issed because there were no mplete it. 10/23/15, at 11:59 a.m. RN-A ion was for staff to complete for residents.	F3	12			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245513	B. WING		10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	;	STREET ADDRESS, CITY, STATE, ZIP CODE 810 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	toileting and persor of bowel. R126's care plan da had an alteration in decreased mobility, bowel. Further, the complete, "Pericare [morning] and HS [I care plan did not id should be complete with those set times. During interview on stated he was depericares after havinowever he did not assistance with this stated his bottom was too long, so he would be pan, and place himself to prevent the soiled while he wait pericares. When interviewed on ursing assistant (NR126 with toileting noticed feces soiled before. NA-A state using it as a barrier becoming soiled who buring interview on registered nurse (RR126 was using the	ated 10/12/15, identified R126 his elimination related to but remained continent of e care plan directed staff to e with assist of 1 with amour of sleep] cares." The entify if or when pericare ed for toileting not associcated	F 312			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245513	B. WING		10/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	;	STREET ADDRESS, CITY, STATE, ZIP CODE 810 LAKE BOULEVARD BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 315 SS=D	10/28/15, authored times [R126] would the newspapers un arrival. He had the himself on bedpan, was done." A letter submitted p 10/30/15, authored to use newspaper utold him he didn't nuchange linen if it go newspapers under A facility policy on the requested, but none 483.25(d) NO CATI RESTORE BLADD Based on the residuassessment, the facility goatheter resident who enters indwelling catheter resident's clinical contact catheterization was who is incontinent of the treatment and servinfections and to refunction as possible to the service of the facility fassess and develop	by NA-T noted, "A couple of have his light on but he put der him prior to the [NAs] bedpan within reach and put notifying staff only when he sost survey exit, dated by NA-D noted, "[R126] chose under himself even though leed to do that and we would be soiled. He continued to put him." bileting and pericare was e was provided. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a sign the facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder	F 312		and

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE S COMPL		SURVEY PLETED			
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	reviewed for urinar Findings include: R64's quarterly Mir 9/15/15, identified impairment, require toileting and was, " R64's Nursing Obs dated 9/18/15, ider incontinent" of blac of when he needs The assessment d type of a toileting p implemented for R incontinence. R64's care plan da an, "Alteration in el weakness following "Aware of the need the care plan direc request", and, "Mo patterns and reass request or as need During interview or nursing assistant (I the bathroom wher but has noticed R6 urine" lately. Furth set toileting schedu During observation a.m. R64 was assis NA-F removed a vi pad from R64, and	nimum Data Set (MDS) dated R64 had moderate cognitive ed extensive assistance with Always incontinent" of bladder. servations 3.0 Assessment ntified R64 to be "always ider, and R64 was "not aware to use the toilet appropriately." id not identify if any or what program needed to be 64, to decrease R64's ted 9/21/15, identified R64 had imination r/t [related to] g hospitalization", but R64 was, if to void/defecate." Further, ited staff to, "Toilet per nitor for changes in elimination ess quarterly and prn [per led]." n 10/22/15, at 9:43 a.m. NA)-T stated he helps R64 to he requests as care planned, 4 to be "more incontinent of er, NA-T was unaware of any	F 315	and plan of correction are not admor an agreement that a deficiency exist or that a statement of a defic was correctly cited or factually basit's not to be construed as an admiagainst interest of the facility, the administrator, of any employees, a or other individuals who participated drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care to comprehensively assess and deinterventions for promote urinary continence. To assure continued compliance, the following plan has been put into plant into plant into plant into the same into the plant into the same into the sa	does iency ed and ission agents ed in the or Center evelop he ace; Tontinent ice. Insure ifficant	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE COMF	
		245513	B. WING _		10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	,	
IAKE DII	DGE CARE CENTER	OE BUEFALO		310 LAKE BOULEVARD		
LAKE IIII	DGL CANE CENTER	OI BOITALO		BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	Continued From partial have had an "extra on during the night skin from being incommoved incontiner R64 was typically in when assisted to the Further, NA-F state when he needed to helped him "every to helped him helped	ge 66 absorbent" green colored pad to help reduce irritation to his ontinent. NA-F stated R64's nee pad "was full" of urine, as acontinent in the morning, but e toilet would sometimes void. d R64 was unable to verbalize use the restroom, so she wo hours" to the restroom. 10/23/15, at 11:34 a.m. N)-A stated R64 was able to se the restroom, "Most of the e helped with toileting every ould not be incontinence of couple times a day," with his the assessment completed on e identified a toileting program continence. essment identified him as " of bladder, and R64 was "not needs to use the toilet ere was no indication if R64 d toileting program, or was a (no attempts to place on the R64 had been using the toilet, e did have some continent urinary incontinence was e was provided. DENTS FREE OF	F 31	Facility practices on Care Planning Toileting were reviewed and revise needed, with education provided to licensed staff by 13 Dec 15. Daily meetings were established on 30 to also aid in capturing residents potentially at risk. MDS's will be completed upon admission, quarte with significant changes, to determindividualized toileting program. 4. Effective implementation of action be monitored by: Facility will complete five NAR Car Observations weekly for three monthered three months for individualized toil program. The data collected will be presented to the Quality Assessment & Assurance Committee quarterly. At time the Quality Assessment & Assurance Committee quarterly. At time the Quality Assessment & Assurance Committee quarterly. At time the Quality Assessment & Assurance Committee quarterly. At time the Quality Assessment & Assurance Committee quarterly. At time the Quality Assessment & Assurance Committee quarterly. At time the Quality Assessment & Assurance Committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing is response compliance.	g and id, as of IDT Dot 15 orly and nine the ins will enths. hly for eting ie ent & At that surance ing any g to be	12/29/15
00-0		sure that residents are free of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	26/2015	
NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP			
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 333	by: Based on docume facility failed to ensignificant medica (R45) who had a n	ENT is not met as evidenced ent review and interview, the sure residents were free from tion errors for 1 of 1 residents nedication error in which they	F3	F333-D Facility timely submits this plan of correction pursuant state law requirements. The	to federal and nis response		
	Findings include: R45's annual Minis 8/11/15, indicated intact, had diagnos received daily insurable. Review of the Buff report dated 4/8/15 instructed by the content of the suggestion of the Buff report dated 4/8/15 instructed by the content of the suggestion o	falo Clinic Telephone order 5, indicated the facility was linic to notify the physician if gars below 80 5 (mg/dl), normal blood sugar		and plan of correction are read or an agreement that a defexist or that a statement of was correctly cited or facture it's not to be construed as against interest of the facility administrator, of any employor other individuals who parafting or who may be discontentiated the same of the policy of Lake Ridge to ensure that residents are significant medication error. To assure continued completely of the policy of Lake Ridge to ensure that residents are significant medication error.	iciency does a deficiency ally based and an admission ty, the oyees, agents rticipated in the cussed or me. ge Care Center e free of any rs. liance, the		
	which included phy indicated R45 was acting insulin] as of units in the mornin now." The Lake Ridge C Order (PO) Report Lantus 37 units su The PO did not dir dose of Lantus. An Allina Health of	ta Health Clinic Buffalo note sysician orders dated 4/16/15, to, "Continue Lantus [long of the last dosage which was 37 tg. No night time dosage for are Center signed Physician t dated 4/20/15, indicated boutaneous once in morning. Tect staff to give a night time of the continue of the		1. Regarding cited resident Resident 45's insulin order medical provider on 27 Apr and HUC were identified th responsible for transcription Medication error event was received education on Medicand transcription; both nursulonger employed at facility. 2. Actions taken to identify or residents having similar oc All residents who receive in potentially at risk from this	ts: clarified by r 15. Nurses nat were n of the insulin. s created. HUC dication error ses are no other potential currences: nsulin are		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245513	B. WING _		10/2	26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 333	at bedtime." Hower R45 had been recase the resident had units in the morning units more of insul receiving. The faci increase in insulin Allina physician. Review of R45's D 4/1/15, to 4/30/15, in the morning. Hower Hammer Ham	ever, there was no indication eiving Lantus at bedtime prior, d only been taking Lantus 37 g. Although this PO added 37 in, than R45 was currently lity did not clarify the significant R45 was to receive from the iabetic Administration History indicated Lantus 37 units once owever, on 4/20/15, Lantus at was implemented, along with in the morning; doubling	F 3:	Residents who receive insidentified and medical proverified for accuracy again 3. Measures put in place to deficient practice does not Licensed staff and HUCs reducation on diabetes, trainedication orders by 13 Diprocedure for transcription errors reviewed and revise verified by licensed nurse transcription. 4. Effective implementation be monitored by: Five residents who have in have MD orders verified a monthly for three months. collected will be presented Assessment & Assurance quarterly. At that time the Assessment & Assurance make the decision/recommake the decision/recommake the decision/recommon regarding any necessary fineeding to be continued. 5. Those responsible to make compliance will be: The Director of Nursing is compliance. Completion date for certificationly is: 29 Dec 15	vider orders ast eMAR. ensure trecur: will receive and medication ed; orders will be after of actions will asulin orders will gainst eMAR The data to the Quality Committee Quality Committee will mendation ollow-up audits aintain responsible for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG			SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE 310 LAKE BOULEVARD BUFFALO, MN 55313	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 333	not indicate the phy blood sugar, nor did residents insulin hat R45's Resident Pro 8:33 a.m. indicated sugar) this morning She had a BS of 38 8:44 a.m. and upda A Buffalo Clinic Tele indicated on 4/27/15 called the clinic regmorning of 38 mg/d Communication for Ridge called the clinic patient should actual bed time, as the factorders did not mate A Buffalo Clinic Tele 4/27/15, medical dop.m., "Discussed wid/20/15, visit had wunits at bedtime, who daily MORNING Dopatient has been redaily since the last sugars." MD-B ordidaily in the morning R45's Resident Pro 5:37 p.m. indicated Lantus 37 units BID miscommunication appointment. Spok dose has been d/c'd	discian was notified of the low of the facility identify the discinity identified at the lower identified	F3	33			

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	nursing (DON) statinsulin medication of R45, and stated ship medication of R45, and stated ship medication error renurses should have they noted the order on 4/20/15, since the that dose before, a current insulin she stated that she had residents orders to problem. DON stating related to the because she was muntil survey on 10/2 error occurred. Although R45 was in morning only, and the order to double 4/20/15, the facility physician the additionate HS, nor did the fawhen R45 had low 4/25/15, and 4/26/11 the physician until 4 insulin dose was do a low blood sugar of symptoms. Also, the looked at other resigner vent other poter 483.30(a) SUFFICI	d/26/15, at 9:30 a.m. director of ed she was not aware of the error that had occurred for e was unable to locate a port. The DON stated the e called the physician when er for Lantus to be given at HS he resident had not received and the order was doubling the was receiving. The DON not checked any other see if this was reoccurring ted she did not do any staff he significant medication error, not aware the error occurred 26/15, six months after the previously on Lantus 37 units d had a history of low BS after the residents insulin dose on failed to clarify with the onal order of Lantus 37 units acility contact the physician blood sugars on 4/22/15, 5. The facility did not contact 4/27/15, 7 days after R45's publed, when the resident had of 38 and experienced ere was no indication they dents, and educated staff to intial medicaiton errors. ENT 24-HR NURSING STAFF	F 33			12/29/15
SS=F		ive sufficient nursing staff to d related services to attain or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245513	B. WING		10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	maintain the higher and psychosocial of determined by resindividual plans of the facility must pnumbers of each opersonnel on a 24 care to all resident care plans: Except when waive section, licensed represonnel. Except when waive section, the facility nurse to serve as duty. This REQUIREMED by: Based on observative review, the facility staffing to ensure assistance with careviewed for dignification (R73) residents (R73) residents (R5) reviewed for the 48 resident R126) reviewed for residents (R5) reviewed for 5 of 6 residents R126) reviewed for (ADLs). In addition R55, R85, R118, F2 of 4 family memins a staff members	est practicable physical, mental, well-being of each resident, as ident assessments and	F3	F353-F Facility timely submits this replan of correction pursuant state law requirements. This and plan of correction are nor an agreement that a defice exist or that a statement of a was correctly cited or factualit's not to be construed as a against interest of the facility administrator, of any employ or other individuals who par drafting or who may be discotherwise identified the same	to federal and is response ot admissions ciency does a deficiency ally based and n admission y, the yees, agents ticipated in the ussed or ne.	

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	` '		SURVEY
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	COTA-J, SM-A and concerns and comp staffing. This lack to affect all 48 residence the facility. Findings include: ASSESSED RESIDMET: > Refer to F242: The standard preference reviewed for bathing preference reviewed for bathing the standard prompt responses staffing concerns. 5 of the 48 resident R21) who regularly meetings from 7/28. > Refer to F282: The care as directed by residents (R5) reviewed for 1 of 5 activities of daily living dependant on staff. RESIDENT CONC.	I SM-B) interviewed expressed plaints related to insufficient of sufficient staff had potential dents who currently resided in DENT NEEDS NOT BEING The facility failed to honor is for 1 of 3 residents (R73) in g choices. The facility failed to ensure to grievances related to This had the potential to affect its (R27, R19, R45, R35 and attended resident council in attended resident council in the facility failed to provide oral by the care plan for 1 of 3 rewed for dental hygiene. The facility failed to ensure nailed for 2 of 5 residents (R5, pleted for 2 of 5 residents (R5, pleted for 2 of 5 reviewed for ring (ADLs) and who were	F 35	to have sufficient nursing staff to prinursing and related services to attain maintain the highest practicable phymental and psychosocial well-being each resident, as determined by responding the provided with plans of the services assessments and individual plans of the services assessments and individual plans of the services of the services assessments and individual plans of the services of the services assessments and individual plans of the services of the services assessments and individual plans of the services o	in or ysical, of sident of care. In or care. In or care. In or care. In or care of ndings how the cited of cate of care of ndings how the cited of care of care of ndings how the cited of care of car	

Facility ID: 00714

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	E SURVEY PLETED
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	10/1	20/2010
	DGE CARE CENTER			31	0 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	complete ADLs. During interview or stated he had to whis call light answer cares. R126 state use the restroom a he never knew how answer his call light "Anxious," and "He interview on 10/26, his preference was toileting and not a response times, he stated, he need he commode, but is uralone, and has to wreported he would commode for toilet because he does not respond to timely to help onto use the bedpan and prefers to use. R55's quarterly MER55 had moderate required limited as During interview or stated she often had time to get help to frequently incontinuors. R55 stated	n 10/22/15, at 3:22 p.m. R126 ait up to thirty minutes to have wred to receive assistance with d he needed staff assistance to and get into his wheelchair, and w long it would take staff to at and that made him feel, elpless." During a follow-up (15, at 10:00 a.m. R126 stated to use a commode for bedpan. However, due to long to often utilized a bedpan. He lp to get on and off the nable to get onto the commode wait for staff to help. R126 have much rather used a ling and not a bed pan, "It get as "messy," But staff to his call light for assistance the commode, so he has to d not the commode, which he of the local stance from staff for ADLs. In 10/20/15, at 9:13 a.m. R55 and to wait for extend periods of the bathroom, and was ent because of waiting for so the facility needed more staff to their cares, "They just don't	F3	53	schedules have been re-created, a posted for two-week time periods of and any vacant positions are posted the schedule. These vacant hours available to current employees, and also called in to a pool agency if the cannot be filled before the pay periodegins. Variably, weekly orientation also been implemented to assist in getting onto the floor. Bonuses have and will continue to be offered to fill vacant shifts, as well as increased differentials. Advertisements for nuand nursing assistants have been a continue to be placed in local pape online sources, such as Indeed, un positions are filled. Locations that nursing assistant programs have be contacted to let them know of any of positions and how we can partner together to attract more applicants. Suggestion box was put into use to input from employees, as well as us annual reviews and the EQIC meet address potential job duty issues. Employees were educated on what doing to attract new employees. Whoping to hire a staffing coordinator assist in scheduling and shift replacement. To allow for the propof our residents, we have also addenew position, Resident Concierge Representative, to help assist in the needs of our residents. 4.Effective implementation of action be monitored by: Open positions and vacant shifts we recorded on the schedule and an expected or the schedule and an expected or the schedule and an expected or the schedule	r more, d on are d are ey od have staff ve been linight urses and till open provide een open A solicit sing ing to All we are ve are red on a een as will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245513	B. WING		10/	26/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 353	R85's quarterly MI had intact cognitio assistance from st During interview o stated the facility had the past two or thr takes, "Quite awhiprovide assistance big annoyance." R118's admission R118 had intact coassistance from st During interview o stated staffing see in the evenings. Further than the evenings of that needed to be resident had to wa complete this which become saturated R5's quarterly MD had intact cognition assistance from st During interview of stated the facility of staff would often of staffed to him, and was only one nurs R5 stated his call liminutes," to get an experience of the staffed to him, and the staffed to get an experience of the staffed to	OS dated 9/1/15, identified R85 n, and required extensive aff to complete ADLs. In 10/20/15, at 10:03 a.m. R85 and been, "Short of staff," for see months. R85 stated staff le" to answer his call light to a with cares, and it had, "Been a MDS dated 8/24/15, identified agnition, and required limited aff to complete ADLs. In 10/21/15, at 11:34 a.m. R118 ms worst on the weekend and at 18 had a dressing change completed, however, the it over 6 hours for staff to the caused the dressing to and drip fluids. In 10/20/15, at 9:11 a.m. R5 lid not have enough staff, and omplain about being short at times R5 had stated there working for an entire shift. ight will take, "Fifteen to twenty iswered, and was once left on "An hour and a half," before	F3	explanation of how those open or vacant shifts were covered we written in the nursing schedule. Cannot be filled for some reasor Director of Nursing will be contained that contact, time and vacancy written in the nursing schedule. Director of Nursing will inform the Administrator weekly for two moopen nursing department positions shifts unable to be filled and the action to fill those positions and as needed thereafter. All-staff rewill be held monthly for three mediates and the example of the ex	Il be If a shift , the cted, and vill be rook. The e nths of ns and course of shifts, and neetings onths. ment equate ida, with d to the ide a o discuss successful etings will ge. on the e, with being anges with not. be I be prove and ected will essment & meeting ake the ding any	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313	10/.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Continued From pa	ge 75	F3	353			
	R73 had intact cogi	DS dated 10/1/15, identified nition, and required extensive off to complete ADLs.			5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.		
	stated he had waite past for staff assist call light to be answ over worked and ur	10/21/15, at 10:55 a.m. R73 and for nearly two hours in the ance to go to bed and for his vered. R73 stated the staff are needed and for the residents necessary cares in the facility.					
	R35 had moderate	S dated 10/6/15, identified cognitive impairment, and assistance from staff to					
	stated the facility st the time, and there have to wait to use	10/20/15, at 10:29 a.m. R35 aff worked short nearly all of had been times R35 would the bathroom but was not receiving timely assistance the restroom.					
	R123 had intact cog	MDS dated 10/15/15, identified gnition, and required extensive iff to complete ADLs.					
	stated she had wait to the restroom, car	10/20/15, at 12:20 p.m. R123 red for over an hour to get help using her to, "Just use my stated made her, "Feel					
	R27's quarterly MD	S dated 9/22/15, identified					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	R27 had intact cograssistance from stated she had waither call light answe the facility needed to the cares the resident the cares of waited, and waited, staff to respond. The concurrences of waited answered, and FM-response times] continuity the concurrence of the president they were "Adequated disagreed and the fix they had been told they were "Adequated they were "Adequated they were at the facility. The concurrence of the care they are concurrence of the care they are concurrence of the care they are care to care they are care they are care they are care to care they are	inition, and required extensive ff to complete ADLs. 10/20/15, at 10:24 a.m. R27 ed for over an hour to have red to receive assistance, and to have more staff to provide ents needed. NT'S ABOUT STAFFING: 10/21/15, at 11:31 a.m. family ated they had visited their is past and used the call light distance and "Waited, and" over twenty five minutes for here had been multiple ing for the call light to be G stated, "It [long call light incerns me." FM-G stated the owners of the facility felt ely staffed," but stated she acility needed to add more its with cares. 10/26/15, at 10:01 a.m. FM-H ed oral cares were frequently displayed because of the lack of stafficall light had taken over one din the past, and was	F3	553			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10)/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 353	with cares. NA-G complain about the and lack of assista NA-G stated the so (nail care, shaving because of the lac don't have enough residents." NA-G sinjured attempting by themselves bed staff on to help us administration tells but rarely help staf ensure they are be During interview or housekeeping aide had been short stahad made resident extended periods, rooms and hear reme." HA-A stated concerns staff is uncares, but they tell add more staff, "But During interview or stated the staffing and there was frequench hallway to promote they should good members were injured for so long, and attempted to roll residents for solong, and attempted to roll residents."	stated the residents often e long call light response time ince they receive with cares. Cheduled baths and grooming is not always completed k of staffing adding, "[staff] time to take care of the stated several staff had been to care for two assist residents eause, "There's not enough out." NA-G stated the facility is staff they, "Are looking into it," of provide the resident cares to eing completed. In 10/22/15, at 10:53 a.m. In (HA)-A stated the nursing staff offed lately. The lack of staff is have to wait for help for and HA-A will often walk by sidents asking, "Help me, help administration is aware of the nable to assist residents with employees they are trying to	F3	353		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10	/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP COE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 353	stated the staffing was supposed to he for the residents du frequently is left wit at times on the ween nurses and two NA residents, and on the received their schenot made because. During interview on stated the facility we care was suffering instances of only offor residents in the the residents have and attention. NAgrooming of residentimes," because of the administration hage and talked about however, nothing having enough staff been discussed. During interview on stated staffing at the horrible," and residents had to get their call light [staff] don't have tir administration had cares, but "they expect work done and only you guys [state sur	was "awful," adding the facility ave six or seven NA's to care uring the morning shift, but honly four NA's. NA-C stated exend there would be just two 's to care for all of the nat weekend, no residents duled bathing, and beds were of the lack of staff. 10/22/15, at 1:53 p.m. NA-T as short staffed and resident as a result. There had been ne NA on each hallway to care past, and when that occurs to, "Just wait," to receive care T stated the bathing and at had suffered, "Lots of the poor staffing. NA-T stated neld a meeting a few months ut solutions to short staffing, ad been done to improve not f, and nothing further had 10/22/15, at 2:20 p.m. NA-K e facility was, "Absolutely ent care was suffering. NA-K equently not even a nurse unit (an end-of-life care unit), o wait for long periods of time is answered because "We ne," to answer them. The done nothing to help with pect" the floor staff to get the recome onto the floor, "When	F 35	53			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 353	licensed practical r "Not adequate," to needs, and she wa facility because she and felt it was bein the lack of staffing as a result. During interview or stated she felt the staff to provide the and residents had and families voice regarding the suffe poor staffing. LPN dressing changes n urse did not have trying to help provio other residents. During interview or registered nurse (F a "big issue" at the short of help and th overall. RN-A state because of the poo had never asked th to balance the worl staff's input on how situation. During interview or occupational thera therapist assistanc could use more he they hear from resi and waiting, "Way answered. OT-K a	age 79 hurse (LPN)-F stated staffing is care for the residents and their is quitting her position at the evalued her nursing license, g put in jeopardy because of and poor care being delivered in 10/23/15, at 7:07 a.m. LPN-B facility did not have enough necessary care to residents, to wait to get up for the day, frustration to the staff ering care as a result of the -B stated she recalled some weren't completed because the time because they were busy de the necessary care for the in 10/23/15, at 11:52 a.m. and all the residents care was suffering and several staffing had been facility. The floor staff are ne residents care was suffering and several staff had resigned or staffing, and administration he staff about changing hours k better, or asked for floor or to handle the short staffing in 10/26/15, at 2:32 p.m. pist (OT)-K and occupational le (OTA)-J stated the floor staff lp, and the biggest complaint idents was the lack of staffing too long for [call] lights," to be and OTA-J stated they were not as being taken by the facility to second the staff and the short staffing the lack of	F 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		 	10/;	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			31	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	address the short During an anonymmember (SM)-A, swith concerns about SM-A stated the sand administration the past few days surveyors] are hele home after their swere unable to conthe residents, "The SM-A stated severecent shift, but on and SM-A was told (DON) to sign the were completed. "Really upset," an with cares on the only being done, "surveyors] are hele only being done, surveyors] are hele only being done, and surveyors are hele only being done, surveyors, and groom three staff on the residents. SM-B sadministration regulation regulations and groom however, nothing. The facility LRCC documents, which staff working on the 10/19/15, to 10/23 document identifice (Oasis, Lake View	staffing concerns. nous interview with a staff several issues were presented but the lack of staff in the facility. It is taffing was, "bad" at the facility, in was pulling in people to work "Because you guys [state re." SM-A stated they often go hift and feel bad because they implete their jobs and care for e cares are just not good." It is real baths were scheduled for a nally two of them were completed do by the director of nursing care sheets identifying they SM-A stated that made her, it is stated administration helping floor was not typical, and was because you guys [state]		353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		1	0/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, 2 310 LAKE BOULEVARD BUFFALO, MN 55313		,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 353	> On the AM shift, no staff names ide work on the unit. I Northwoods each staff were schedul just one nurse and document identifie used to identify state > On the AM shift, had no staff names to work on the unit Northwoods had on nurse, and on providing care for identified six of the identify staff, to be > On the AM shift, had no NA display assigned to provid Northwoods had on provide cares to the identified seven of identify staff, to be > On the AM shift, had no nurse identified seven of identify staff, to be > On the AM shift, had no nurse identified seven of identify staff, to be > On the AM shift, had no nurse identified seven of identify staff, to be > On the AM shift, had one nurse and cares. The docum spaces used to identify staff, to be > On the AM shift,	ame was written to identify needuled to work. 10/19/15, the Oasis unit had ntified as being assigned to will Creek Bridge and had open spaces identifying noted to work; and were left with one NA for each unit. The disk of the thirteen spaces off, to be blank. 10/20/15, the Oasis unit again is identified as being assigned. Mill Creek Bridge and pen spaces with no staff Both units continued with just it is NA working on the floor of the residents. The document of thirteen spaces used to blank. 10/21/15, the Mill Creek Bridge ed, only having a nurse ecare to the residents. The document of the thirteen spaces used to	F3	553			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	have a nurse identifive of the thirteen be blank. On 10/26/15, at 5:0 (DON) stated, "Rig staffing. It is the distated, "We work we resources] all the tistaff." The DON ace verything else that quality deficiencies concerns] There not be an issue if we floor." The DON si was well aware of the analytic and the quality con insufficient staffing staffing shortage be summer when study there were also eigmaternity leave as facility was still acceptant to the week were delated in the week were discharged. When identified or address were not receiving stated, "This is one staffing we were second week of Set to have a bath aide September I think good wash ups."	and the Lake View Lane did not ified. The document identified spaces used to identify staff, to 26 p.m. the director of nursing ht now we are just stuck on the river of all the other evils." She with corporate HR [human me to get and retain good cided, "I think that almost the wive identified [as potential] are tied into it [staffing are so many things that would we had enough people on the rated the facility management the facility's staffing shortage cerns resulting from an DON stated the facility's regan around the end of lents returned to college, and the facility staff who had left on well. The DON confirmed the epting new admissions, but ayed some admissions until then another resident was asked whether the facility had seed concerns of residents who boths or oral cares, DON of the things that is tied to doing great until the first or eptember We are supposed to [but] have not had one since of everybody is getting really in 10/26/15, at 4:24 p.m.	F3	353			
		d the facility staffing was					

NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 83 if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTIO		PLE CONSTRUCTION IG		E SURVEY IPLETED		
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 83 if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of			245513	B. WING _		10/	26/2015
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 83 if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of			OF BUFFALO		310 LAKE BOULEVARD	•	
if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided.	F 356	if they, "Have a lot needs." The facility down in census, ar number of hours di residents) to deterr resident, so being a mount of dollars." had, "Certainly ider staffing, and the for staff adding it had a time." A facility policy on a none was provided 483.30(e) POSTED INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per seriedent care per seriedent care per seriedent care per seriedent census. The facility must post of each shift. Data o Clear and readab o In a prominent plant.	of residents that have more y does cut hours if they are not uses a formula (total ivided by the number of mine the number of hours per down one bed equals, "X". The administrator stated he notified there is a problem" with cus was to hire and recruit new been the focus, "For a long staffing was requested, but and the actual hours worked tegories of licensed and staff directly responsible for hift: urses. Setical nurses or licensed (as defined under State law). The adaptive staffing data is a daily basis at the beginning a must be posted as follows: ole format. acce readily accessible to	F 35			12/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	26/2015	
_	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP (310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 356	make nurse staffir for review at a cosstandard. The facility must restaffing data for a required by State This REQUIREMED by: Based on observeriew, the facility posting was updated start of each shift working for each sall 48 residents in who wished to reversible to the start of each shift working for each sall 48 residents in who wished to reversible to the start of each shift working for each sall 48 residents in who wished to reversible to the start of each shift working for each sall 48 residents in who wished to reversible to the start of each shift working for each sall 48 residents in who wished to reversible to the start of each shift working for each sall 48 residents in who wished to reversible to the start of each shift working for each sall 48 residents in who wished to reversible to the sall 48 reside	age 84 upon oral or written request, and data available to the public struct to exceed the community maintain the posted daily nurse minimum of 18 months, or as law, whichever is greater. ENT is not met as evidenced ation, interview, and document failed to ensure the daily staffed in a timely fashion at the to reflect the actual employees shift. This had potential to affect the facility, staff, and visitors iew the information. In on 10/26/15, at 4:32 p.m. the Center Report of Nursing Staffed ple for Resident Care posting a hard plastic holder attached to sing station. The posting gistered nurses (RN), two nurses (LPN), and four nursing ere working at the facility on the time period of "6:00 am to totom of the posting identified, aff on duty at any given time all staff working on the floor. It is a staff working on the floor. It is a staff working on the floor. It is a staff working on the floor.	F3	F356-C Facility timely submits this plan of correction pursuant state law requirements. The and plan of correction are ror an agreement that a defexist or that a statement of was correctly cited or facturit's not to be construed as a against interest of the facility administrator, of any employ or other individuals who part drafting or who may be discontentiated the same of the policy of Lake Ridge to ensure that the daily posthours is updated in a timely start of each shift. To assure continued complet following plan has been purely staff posting will be uptimely fashion at the start of each shift.	to federal and his response not admissions iciency does a deficiency ally based and an admission ty, the byees, agents rticipated in the cussed or me. The Care Center sting of nursing y fashion at the tinto place; ts: pdated in a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2	2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) MPLETION DATE
F 356	"Nurse of TMA [trai "LPN/TMA", and "N registered]." The s (RN and LPN), alth three RN's and two working on the floo indicated four NA's Shift 6a [am] - [to] 6 blank spaces left or names being identi. During interview on stated the night shirt posting and display station. When ther scheduled staff, it of the actual staff wor stated, "I don't think changed." During interview on director of nursing or responsible to ensure correct and display night shift, the post the actual number of "Once its up, I kind posting should be uall times, "Because A facility Posting of 12/10/14, identified displayed, "Daily by nurse currently in chowever, the policy	eadings including, "RN", ned medication aide]", IAR [nursing assistant, heet identified only two nurses ough the posting indicated LPN's, and three NA's to be r, although the posting on 10/26/15, during the "Day Sp [pm]." The sheet had seven the sheet with no staff fied. 10/26/15, at 5:35 p.m. LPN-A ft staff fills out the daily staff is it on the wall by the nursing e are changes to the loes not get updated to reflect king on the floor, and she is they [staff postings] ever get at they [staff posting was ret the staff posting was ret the staff posting was ret the staff working on the floor, a leave it." DON stated the updated timely and accurate at its a requirement." Nursing Hours policy dated the posting is completed and it the Clinical Coordinator or the harge of the department."	F 356	2.Actions taken to identify other poresidents having similar occurrence. All residents had potential to be affected by this deficient practice. 3.Measures put in place to ensure deficient practice does not recur: Education was provided to staffected addressing the components of this deficiency related to the posting of hours, and policy for posting staffir hours will be reviewed and revised include procedure for updating too staffing changes by 13 Dec 15. 4.Effective implementation of action be monitored by: The Director of Nursing, or their dewill audit posting of staffing hours of weekly basis for three months. The collected will be presented to the CAssessment & Assurance Commit meeting, quarterly, and at that time QA&A committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is respons compliance. Completion date for certification proonly is: 29 Dec 15	staffing ag to with signee, on a e data Quality tee e the ag any g to be	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 371 F 371 SS=E	The facility must - (1) Procure food froconsidered satisfact authorities; and	ROCURE, /SERVE - SANITARY om sources approved or story by Federal, State or local distribute and serve food	F 37 ⁻		12/29/15	
	by: Based on observa review, the facility f stored in a safe ma cross contaminatio refrigerators observa had potential to affe could have consum foods that was und Findings include: During the initial to 10/19/15, at 6:21 p refrigerator was op fridge had 4 shelve was a plastic conta un-cooked chicken labeled, "CHX [chic and there were visi the bottom of the c the raw meat conta including a white tree	ur of the facility kitchen on the and inspected. The s, and sitting on the top shelf iner which contained a single, breast. The container was sken] BREAST - RAW - 10/17," ble light pink colored juices on ontainer. The shelves below ined several other food items		F371-E Facility timely submits this response a plan of correction pursuant to federal a state law requirements. This response and plan of correction are not admission an agreement that a deficiency doe exist or that a statement of a deficiency was correctly cited or factually based a it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agent or other individuals who participated in drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Cere to ensure raw meat is stored in a safe manner to reduce cross contamination. To assure continued compliance, the following plan has been put into place.	and e ons s cy and on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)) BE	(X5) COMPLETION DATE
F 371	approximately five of Spanish rice. During observation 10/21/15, at 9:11 a container with raw Norlake refrigerate there was now an raw turkey burger "T. Burgers 10/15 non-sealed, baggeremained underned chicken and turker During interview of (CK)-A stated raw the top shelf becaspills, it would constated raw meat, "[shelf]." CK-A stated raw meat, "[shelf]." CK-A stated raw meats should be stored to the containers of refrigerator and, "should be stored to the containers of refrigerator and the containers of refri	plastic container without a lid of non-sealed, bagged servings on of meal preparation on a.m. (two days later) the plastic chicken remained in the or on the top shelf. However, additional plastic container of patties on the top shelf labeled, and 10/18". The plastic tray of ed vegetables and Spanish rice eath of the containers of raw y burgers. In 10/21/15, at 9:48 a.m. cook meats should not be stored on use if the container leaks or taminate the other foods, and Should be on the bottom ed she received training when york in the kitchen that, "Meat	F 37	The Dietary Manager immediately the covered/sealed pan of raw chicken/turkey to the bottom shelf surveyor notification of finding on 2 15. This action was taken per survecommendation. 2. Actions taken to identify other poresidents having similar occurrence All residents served out of the mai kitchen had the potential to be affet the issue cited in the statement of deficiencies. 3. Measures put in place to ensure deficient practice does not recur: Refrigerator and Freezer Storage was changed to reflect that all raw will be stored on bottom shelving 2 15. The Dietary Manager began educating the Dietary staff on the surveyor's recommendations to straw meats on the bottom shelving immediately. All Dietary employee educated by 11 Nov 15. 4. Effective implementation of action be monitored by: The Dietary Manager, or designee audit the storage of raw meat in the refrigerators to insure safe practice followed. Audits will be done week one month and then quarterly for smonths. 5. Those responsible to maintain compliance will be: The Dietary Manager is responsible the overall compliance.	upon 21 Oct reyor's otential es: n octed by policy meats 27 Oct ore all es were ons will e es are ly for six	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412 SS=D	potentially contain be illness if the juices of illness if the juices of	icken and turkey could racteria and cause food borne were spilled onto other foods. ator and Freezer Storage 4, identified, "Meats or other ed in the bottom of the melting liquids do not drop All food items will be stored in the drippings from the tribute in the tribute in the stored in the bottom of the melting liquids do not drop all food items will be stored in the tribute in the stored in the tribute in the stored in the stored in the stored in the stored in the extent stored in the extent stored in the stored in the extent in the stored in the dentist's office; and residents with lost or	F 3	112	Completion date for certification pure only is: November 11, 2015 F412-D Facility timely submits this responsion of correction pursuant to feder state law requirements. This responsion of an agreement that a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or the construed as an admission of the facility, the	e and ral and onse ssions does ency ed and	12/29/15

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/	26/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		20/2013	
LAKE R	IDGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 412	During observation R85 was seated in had visible missing his upper denture is spoke. R85 stated "Worn down", and R85 stated at times because of the loos like to have them loos like to have them loos dentified R85 had visits the facility. T [patient] has full uppartial denture is no remaining lower tegumline Both full extreme occlusial won both for retention upper only" The plan of, "Will tx [tree lower dentures and can refer to an oral remaining lower test and can refer to an oral remaining lower test and can refer to an oral remaining lower test and the lower roots extract then have a new full discuss resident and if he consult to pursue identified in R85's in the lower roots extract the lower roots extra	non 10/20/15, at 10:10 a.m. his room in a wheelchair. R85 it teeth on his lower palate, and moved in his mouth while he his dentures were getting, were, "Not effective anymore." Is he had trouble chewing food se fitting dentures, and would booked at by a dentist. Tess Notes dated 8/11/15, been seen by the dentist who he dentist identified, "Pt per and lower partial. Lower of anchored on any teeth as all eith are fractured off at the lupper and lower partial have wear, and pt it using adhesive in. Pt is interested in new dentist identified a treatment at] plan full upper and full if if pt decides to proceed, we as seen by In House Dental was seen by In House	F 4	administrator, of any employe or other individuals who partic drafting or who may be discus otherwise identified the same. It is the policy of Lake Ridge 0 to ensure dental recommenda acted upon in a timely manne. To assure continued compliant following plan has been put in 1. Regarding cited residents: Resident is alert and orientate signed consent form for facility vendor but then chose to go to dentist. Social Worker met with 412 to review resident prefere dentures on 26 Oct 15, and an consult was completed on 3 Nappointment is scheduled with surgeon to proceed with the diprocess. 2. Actions taken to identify other residents having similar occur Medical records or designeer dental visit log to ensure resident pending dental needs have for in place. Modified Resident Couestionnaire was asked of reensure dental needs are met a resident preference. 3. Measures put in place to endeficient practice does not reconcern to dental vendor not bein meet resident needs within face.	care Center ations are r		

Facility ID: 00714

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			SURVEY PLETED		
	245513	B. WING			10/2	26/2015
	OF BUFFALO		3	10 LAKE BOULEVARD		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
registered nurse (R of the dental recom dental consult, and worker should have and concerns with F During interview on licensed social work aware R85 had bees since "he came" (ac LSW-A stated she were commendations to R85 to be seen by a stated any follow up documented in the unable to locate any addressed. During a follow up in a.m. LSW-A stated and he would like to made, so LSW-A stresident to make a series of the control of the contr	N)-A stated she wasn't aware mendation for R85 to have a stated the facility social followed up on the consult R85. 10/26/15, at 10:22 a.m. (ser (LSW)-A stated she was en requesting new dentures dmitted to the facility), but was not aware of the by the dentist on 8/11/15, for an oral surgeon. LSW-A occompleted would have been progress notes, and she was y documentation it had been thereview on 10/26/15, at 11:21 she had just spoken to R85 or pursue getting new dentures ated she would assist the dental appointment. The ental consultation was ental consultation ental consultation was ental consultation ental consultation ental consulta			IDT stand up meetings starting 30 to monitor for potential dental conce MDS Coordinator for the facility will oral care questions with RAI review contact social worker or designee if needs are required or requested. Seeducation will be provided on oral cobe completed by 13 Dec 15. 4.Effective implementation of action be monitored by: Dental logs will be reviewed monthly medical records or designee for one to ensure timely dental follow up has completed. Facility will complete five audits of residents using the modified CMS QIS Resident Interview Observor modified CMS QIS Non-Interview Resident Observations and facility was complete five NAR Care Observation weekly for three months. The data collected will be presented to the Quarterly meeting. At that time the committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5.Those responsible to maintain compliance will be: The Director of Nursing is responsible compliance.	Dec 15 erns . ask s and dental staff are to ns will y by e year as been ve ed rvation vable will ons uality ee QA&A g any to be ble for	10/00/15
403.00(C) DRUG K	EGIIVIEIN NEVIEW, NEPURI	Г 4	•∠ō			12/29/15
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From paregistered nurse (Rof the dental recomdental consult, and worker should have and concerns with Fouring interview on licensed social work aware R85 had been since "he came" (act LSW-A stated she were commendations to the state of the state	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85. During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85. During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided.	ROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85. During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided.	PROVIDER OR SUPPLIER 245513 REQUIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY) WISS THE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 Continued From page 90 registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85. During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated of the dentist on 8/11/15, tor R85 to be seen by an oral surgeon. LSW-A stated of the dentist on 8/11/15, tor R85 to be seen by an oral surgeon. LSW-A stated of the dentist on 8/11/15, tor R85 to be seen by an oral surgeon. LSW-A stated will be first on 8/11/15, tor R85 to be seen by an oral surgeon. LSW-A stated will be first on 8/11/15, tor R85 to be seen by an oral surgeon. LSW-A stated will be first on 8/11/15, tor R85 to be seen by an oral surgeon. LSW-A stated will be reviewed monthing the provided on oral commented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11/21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided. 5. Those responsible to maintain compliance will be: The Director of Nursing is responsit compliance. Completion date for certification puronly is: 29 Dec 15	ROVIDER OR SUPPLIER DECAMBLE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a dental consult, and stated the facility social worker should have followed up on the consult and concerns with R85. During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was at LSW-A stated she wasnot unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she wasnoble to locate any documentation it had been addressed. A facility policy on dental consultation was requested, but none was provided. A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313 PROVIDERS PLAN OF CORRECTION PREPRIOR (RACH CORRECTION) PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING	· · · · · · · · · · · · · · · · · · ·	10/2	26/2015	
NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		0, 0 10	
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428	Continued From pa	_	F 4	28			
SS=D	IRREGULAR, ACT	ON					
		of each resident must be nce a month by a licensed					
	the attending phys	ust report any irregularities to ician, and the director of reports must be acted upon.					
	by: Based on interview facility failed to ensure recommendations parameters for use residents (R5) reviewedication use. Findings include: R5's quarterly Mini 9/15/15, identified pain, and required activities of daily like identified R5 had costeomyelitis [an immarrow] and a nor	w and document review, the sure the consultant pharmacist to establish pain medication e were acted upon for 1 of 5 ewed for unnecessary mum Data Set (MDS) dated R5 had intact cognition, no extensive assistance with his vings (ADLs). The MDS liagnoses including chronic infection of the bone or bone in-pressure related foot ulcer.		F428-D Facility timely submits this replan of correction pursuant to state law requirements. This and plan of correction are no or an agreement that a deficiexist or that a statement of a was correctly cited or factuall it's not to be construed as an against interest of the facility, administrator, of any employed or other individuals who particularly or who may be discupotherwise identified the same alt is the policy of Lake Ridge to ensure that pharmacist recommendations to establismedication parameters for usupon.	o federal and response t admissions ency does deficiency y based and admission the ees, agents cipated in the ssed or Care Center th pain		
		nedication used to treat pain tablet; 650 mg [milligrams]		To assure continued complia following plan has been put in			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION		SURVEY PLETED
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		3,20.0
					10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO			UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	DX: [diagnosis] paneeded]." "Tramadol [narcoti IV [four] tablet; 50 The signed physici identify any paramnursing staff shoul Acetaminophen vecontrol R5's pain. R5's Consultant Phene Reviews directed to insignificant problems taff: 8/3/15 - " [#5] Plea parameters for usi [versus] Tramadol' 9/2/15 - "Repeat Moreview] 8/3/15 #5 - 10/1/15 - "Repeat Moreview] 8/3/15 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5 - 10/1/16 #5	c-like pain reliever] - Schedule mg; Every 6 Hours - PRN." an orders did not provide or eters or direction for when d administer the rsus the Tramadol to help harmacy Drug Regimen he following, "Potential by [sic] m," to be acted upon by facility se check if there are ng prn Acetaminophen vs?" IMR [medication regimen if not addressed." B/3/15, MMR #5. Does not essed." d was reviewed and there was ensultant pharmacist's were acted upon as requested and 10/1/15, to assist in meters for R5's pain medication 10/26/15, at 9:36 a.m. hurse (LPN)-A stated she would e medications to R5 based on would complain of, however,	F 4	128	1. Regarding cited residents: The cited resident is alert and orien and was interviewed on 30 Oct 201 Resident requested that he be allow continue to request Tylenol as need general discomfort and indicated he longer wanted Tramadol. The pharm recommendation was reviewed and medical provider contacted to discoprn Tramadol on 30 Oct 2015 due to non-use. 2. Actions taken to identify other pot residents having similar occurrence. The pharmacy recommendations from past quarter were reviewed by 29 December 2015 to ensure follow up on pharmare recommendations. Issues noted due the review were corrected for compositions. Issues noted due to the review were corrected for compositions and pharmacy recommendations will be distributed by Director of Nursing to designated nurses for completion. Education was provided on this definition and Pharmacy Medication Regiment Reviews that was completed 13 December 2015 for licensed staff and TMAs. 4. Effective implementation of actions.	5. ved to led for e no macist fontinue o ential es: om the lec acy uring liance.	
	staff were treating reviewed R5's EM/	hed parameters would ensure R5's pain consistently. LPN-A AR (electronic medical ord) and stated there were no			be monitored by: Audits will be completed on 10 residuith pharmacy recommendations may to ensure timely follow up for three		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAKE BOULEVARD JFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	established paramemedications. During interview on registered nurse (Reviews the pharma each visit and upda pharmacy recommendation by parameters for R5's was not addressed, recommendations on, "That's an issue During interview on consulting pharmacy facilities a certain the his recommendation should have address made on 8/3/15, 9/2 "It should be done." A facility policy on management was reprovided. 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Presafe, sanitary and of the help prevent the of disease and infection Control Control (a) Infection Control Co	ters for R5's as needed pain 10/26/15, at 9:54 a.m. N)-A stated the nursing staff acists recommendations after the test the physician with the endations. RN-A reviewed and stated the at the pharmacist to establish as needed pain medications and stated the should have been followed up at a 10/26/15, at 11:14 a.m. the cist (CP) stated he allows me period for staff to address ans, however, the facility ased the recommendations and 10/1/15, and stated, and 10/1/15, and stated, are dication regimen review and requested, but none was a CONTROL, PREVENT Itablish and maintain an an orgam designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control	F 4	S	months by the Director of Nursing, designee. The data collected will b presented to the Quality Assessme Assurance Committee quarterly. A time the QA&A committee will make decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance. Completion date for certification puronly is: 29 Dec 2015	nt & nt & t that e the g any to be	12/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
_	PROVIDER OR SUPPLIER DGE CARE CENTER			31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what personnel must had a policided. (3) Maintains a reconstruction actions related to in the content of the con	controls, and prevents infections brocedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. The ead of Infection control Program resident needs isolation to dof infection, the facility must the ease or infected skin lesions to with residents or their food, if transmit the disease. Set require staff to wash their direct resident contact for which dicated by accepted	F4	141			
	by: Based on observareview, the facility control practices a spread of infection observed during a Findings include:	exition, interview, and document failed to implement infection and procedures to prevent the for 1 of 3 residents (R118) wound dressing change.			F441-D Facility timely submits this response plan of correction pursuant to feder state law requirements. This respondence and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficiency was correctly cited or factually based it's not to be construed as an admission.	al and onse ssions loes ency ed and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY PLETED
		245513	B. WING _	·····	10/:	26/2015
NAME OF F	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE		
				310 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	R OF BUFFALO		BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	Continued From p	age 95	F 44	1		
F 441	identified diagnose lower extremity, no lower right leg with non-healing, and properties activities of daily limitact and required to her supplies, laid a clebeneath R118's rig seated in her when between the towel her hands and applies and soiled stocking bandaging), removed a small scissors absorption pad overight lower leg. The were discarded in scissors were set to use Simply Sali loosen a Silversor dressing) from R1	es including cellulitis of the right on-pressure chronic ulcer of a unspecified severity-beeudomonas in wound. Minimum Data Set (MDS) Intified R118's cognition was a limited assistance for most wing (ADLs). Different and incensed practical is observed completing a construction of R118's open wound to the PN-F gathered the necessary can towel directly on the floor got foot, while R118 remained elchair. No barrier was placed and the floor. After washing olying gloves, LPN-F removed at (a stretchy fabric used for wed the soiled dressing with use is, and then removed the er the open wound to R118's e dressing and absorption pad the trash, but the stockinet and aside, while LPN-F proceeded the Wound Wash to soak and be (antimicrobial wound 18's open wound. Dark brown	F 44	against interest of the facility, the administrator, of any employees or other individuals who participed drafting or who may be discuss otherwise identified the same. It is the policy of Lake Ridge Cato maintain an Infection Control designed to provide a safe, san comfortable environment and transmission of disease and infection To assure continued compliance following plan has been put into 1. Regarding cited residents: Nurse completing the wound calonger employed by facility. 2. Actions taken to identify other residents having similar occurrences and infection that the potential traffected by area cited. 3. Measures put in place to ensudeficient practice does not recurrence and the province of the prevention on Infection Prevention.	s, agents sated in the ed or are Center program itary and o help ection. e, the o place; are is no r potential ences: hanges for o be ure r: on and	
	from the wound ar R118's foot. LPN- debris away from wash to break it up wash, mixed with of from R118's right I towel was visibly sarea beneath R11	was observed to break free and drip onto the towel beneath of removed the dark brown the wound using the saline of and removed it. The saline debris/ slough, was dripping ower leg, onto the towel. The soaked through, in a circular 8's right heel, approximately six of the towel. The soaked through, in a circular 8's right heel, approximately six of the towel. The soaked through, in a circular 8's right heel, approximately six of the towel.		revisions completed with licens 13 Dec 15. Education content facility orientation and with annuin-services related to Infection I reviewed and revised by 29 Dec 4.Effective implementation of a be monitored by: Monitor a random sampling of r with dressing change treatment	used upon ual Prevention c 15. ctions will residents	

CENTER	45 FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245513	B. WING			26/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
		05 BUSEAL 0		310 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313		
(VA) ID	QUIMMA DV QTA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
F 441	cleansing the woun applied new dressir the wound, then plate footrest of her where inward and draped. She picked up her seted the scissors covered the top of I was placed betweemat. She then reacted the stand drawers. At the wheelchair forward the supplies. The right area of the floor the soaked towel. Once accessing the night self-propelled her was me area and return and wiped the towel was placed, the sanitizing wipe from the scissors clean as	ge 96 s and washed her hands after d. At 10:29 a.m., LPN-F ngs and a clean stockinet to aced R118's foot back onto the elchair. LPN-F folded the towel it over the lined garbage bin. supplies and stepped back to the night stand. LPN-F atop a Dycem mat, which R118's night stand. No barrier in the scissors and the Dycem hed to open one of the night his time, R118 self-propelled vard approximately 18 inches, en the drawers and put away ght front and back wheels of was observed to roll over the at became soiled by the e LPN-F had finished stand drawers, R118 wheelchair back through the arned to her original positionF retrieved a Clorox om her medication/treatment flooring beneath where the hen obtained another in her cart and returned to wipe and return it to one of the night J-F did not wipe the Dycem	F4	, ,	will be ssment & ly. At that make the arding any eding to be in ator for the ompliance.	
	R118's night stand. the area and the or had been set aside thin metal bar of R behind the right foo wheel. The stocking	rested the soiled scissors on LPN-F stepped away from iginal (soiled) stockinet which earlier, was draped over a 118's wheelchair, located t rest, near the right front et was observed with multiple, k brown spots of dried wound				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, 2 310 LAKE BOULEVARD BUFFALO, MN 55313	ZIP CODE	10,20,20	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT		
F 441	LPN-F stated it was towel directly on the that drip to the flood dressing changes. Clorox disinfectant the floor after the coshe did not realize through the soiled disinfected it. LF cleaning up the sustockinet from the and it was R118's stockinet and re-us through the laundry about placing the solled pycem mat on R1's had to put it someway typically tried to ke clean dressings and LPN-F stated she where she had set wipe. During interview or registered nurse (F control coordinator sanitizing wipes shoughlies LPN-F gas change. RN-B stated a barrier she between the soiled stand, and the soils sent to the laundry	age 97 n 10/22/15, at 10:51 a.m. s her typical practice to use a e floor to, "Sop up any fluids ir," during R118's wound LPN-F stated she used a wipe to clean the surface of dressing change. LPN-F stated R118 propelled her wheelchair area of the floor before she PN-F stated when she was pplies R118 removed the soiled linens she had gathered, preference to rinse out her se them, rather than send them y. When LPN-F was asked soiled scissors on top of the 18's night stand, she stated, "[I] where" LPN-F stated she ep the scissors apart from her ad to keep it off of the floor, and thought she had wiped the area the scissors with a sanitizing n 10/26/15, at 2:24 p.m. RN)-B, the facility's infection r, stated disinfectant and could have been amongst the thered for R118's dressing ed without a proper barrier LPN-F should have disinfected liately, and if the wheelchair did th the soiled area, it should ad immediately. RN-B also could have been placed I scissors and R118's night ed stockinet should have been and replaced with a clean one. material was obviously soiled it	F 4	41			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245513	B. WING _		10/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
F 490 SS=F	The facility's Infection and Responsibilities the facility's commit developing training personnel on infection precedures. The conforment, with a established infection precautions. The facility includes the use of palong with the deconequipment when extended and the second precedures. The facility must be accommented and the second precedures in the second precedure of the second precedures and the second	laundry for cleaning. on Control Committee- Duties is policy dated 6/14, directed itee was responsible for programs for all facility ion control policies and immittee was also responsible illity maintained a sanitary ill personnel following in control procedures and cility's training program was to protective barrier equipment, intamination and disposal of it posed to blood/ bodily fluids. EVENTE WELL-BEING Idministered in a manner that resources effectively and or maintain the highest land mental, and psychosocial	F 45		eral and conse missions does ciency sed and nission

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				SURVEY PLETED
	245513	B. WING			10/2	26/2015
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF B	ELIEFAL O		3	10 LAKE BOULEVARD		
LAKE HIDGE CARE CENTER OF B	OFFALO		В	UFFALO, MN 55313		
PREFIX (EACH DEFICIENCY MUST	INT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
for 1 of 3 residents (R73 choices, for 5 of the 48 in R35 and R21) reviewed 1 of 4 residents (R126) in ulcers, for 1 of 3 resident dental hygiene, and for R64, R45, R19, and R12 of daily living (ADLs). In residents (R126, R55, R123, and R27), 2 of 4 f FM-H), and 13 of 13 stan NA-I, NA-C, NA-T, NA-K OT-K, COTA-J, SM-A arexpressed concerns and insufficient staffing. This had potential to affect all visitors in the facility. During interview on 10/2 nursing assistant (NA)-C facility needed more stan with cares. NA-G stated complain about the long and lack of assistance the NA-G stated the schedul (nail care, shaving) is not because of the lack of sidon't have enough time residents." NA-G stated injured attempting to care by themselves because staff on to help us out."	sure residents received for 1 of 2 residents nified care and services, 3) reviewed for bathing residents (R27, R19, R45, for group grievances, for reviewed for pressure addition, for 9 of 9 call light residents (FM-G, L48, L48, L48, L58, L59, L59, L59, L59, L59, L59, L59, L59	F 4	90	or other individuals who participated drafting or who may be discussed on otherwise identified the same. It is the policy of Lake Ridge Care (to administer the facility in a manner enables it to use its resources effect and efficiently to attain or maintain highest practicable physical, mental psychosocial well-being of each resources of each resources of the following plan has been put into plant. Regarding cited residents: Facility Administration met with corporate the following plan has developed and implemented action plans for cited deficiencies related to the care and services of residents (Refer to F353). Quality Assessment and Assurance Committee will meet in January to rand revise action plans. 2. Actions taken to identify other pot residents having similar occurrence. All residents had the potential to be affected. 3. Measures put in place to ensure deficient practice does not recur: Facility has added a QAPI meeting conducted between the quarterly Q Assessment and Assurance Committee identified at QAPI. Quality Assessment and Assurance Committee will determine the potential to be a seeded for indicated quality need identified at QAPI. Quality Assessment and Assurance Committee will determine the potential to be a seeded for indicated quality need identified at QAPI. Quality Assessment and Assurance Committee will determine the potential to be a seeded for indicated quality need identified at QAPI. Quality Assessment and Assurance Committee will determine the potential to be a seeded for indicated quality need identified at QAPI. Quality Assessment and Assurance Committee will determine the potential to be a seeded for indicated quality need identified at QAPI. Quality Assessment and Assurance Committee will determine the potential to be a seeded for indicated quality need identified at QAPI. Quality Assessment and Assurance Committee will determine the potential to be a seeded for indicated quality need identified at QAPI.	Center or that stively the I and sident. The ce; corate of the corate of	

Facility ID: 00714

				SURVEY PLETED			
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIEF	1		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO			O LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	housekeeping aidhad been short stathad made resident extended periods, rooms and hear reme." HA-A stated concerns staff is uscares, but they telladd more staff, "Buring interview of stated the facility of care was suffering instances of only of for residents in the the residents have and attention. NA grooming of residents have and attention. NA grooming of residents have and attention helewith all staff and to staffing, however, improve the lack of can be completed followed up regard the needs of the residents have a staffing at the covering interview of stated staffing at the residents had to get their call light and residents had to get their call light.	n 10/22/15, at 10:53 a.m. e (HA)-A stated the nursing staff affed lately. The lack of staff ts have to wait for help for and HA-A will often walk by esidents asking, "Help me, help administration is aware of the mable to assist residents with employees they are trying to ut it takes time." n 10/22/15, at 1:53 p.m. NA-T was short staffed and resident as a result. There had been one NA on each hallway to care e past, and when that occurs e to, "Just wait," to receive care -T stated the bathing and ents had suffered, "Lots of the poor staffing and the cares completed. NA-T stated the da meeting a few months ago alked about solutions to short nothing had been done to of staff to ensure resident cares, and administration had not ding what is being done to meet	F 4	190	compliance regarding action plan ar IDT was educated on QIS Quality Assessment and Assurance Commit and Staff was educated on the role of Quality Assessment and Assurance Committee by 13 Dec 2015. 4. Effective implementation of actions be monitored by: Administrator and Quality Assurance Assessment Committee will monitor action plans and report to corporate assistance in oversight. Action plan be monitored for progress towards of and revised as needed. Quality Assurance and Assessment Commit will determine compliance regarding action plan areas. Administrator with updates on action plan implementation plan areas. Administrator with the months. Elim COO, or deswill monitor Administrators performs monthly for three months to ensure administration has been acting on the concerns identified by staff and resident Council and staff meetings for three months to ensure administration has been acting on the concerns identified by staff and resident Cooperate COO or designee is responsible for compliance.	s will e and for s will goals ittee j ill give ion at s times signee, ance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(3) DATE SURVEY COMPLETED	
		245513	B. WING		10.	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP COL 310 LAKE BOULEVARD BUFFALO, MN 55313		J. 2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 490	cares, but they exp work done and only guys [state surveyor During interview on registered nurse (Ra "big issue" at the short of help and the being completed as several staff had re staffing, and admin staff about changin better, or asked the how to handle the surveyors are here work the past few of surveyors are here home after their shi were unable to complete the cares, and SM-nursing (DON) to sithey were complete there was not enous SM-A stated that me stated administration floor was not typical.	done nothing to help with ect the floor staff to get the come onto the floor when you	F 4	90		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 490	"People are quitting raised concerns ab or three staff on the residents. SM-B st administration regal having enough staff baths, and groomin however, nothing his staffing, and SM-B how administration. During interview on DON stated, "Right staffing [lack of]. It evils." She stated, [human resources] good staff." The Doe everything else that quality deficiencies concerns] There not be an issue if with floor." The DON cowas well aware of the and the quality concinsufficient staffing, of staff is ongoing. management had complemented signifit to be flexible with signification of summer, who college, as well as maternity leave. The was still accepting is one of the things	bus interview, SM-B stated, g because of the staffing," and out some shifts with only two e floor to work and care for the ated they spoke to rding the concern of not f to complete timely toileting, ag because of the lack of staff, ad been done to fix the lack of had heard nothing further on	F	190			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10.	/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	one since Septemb [residents] is gettin. When interviewed administrator stated him regarding the lest [staff] need more president cares. The determined based if they currently had extensive staff assidid cut hours if they and use a formula by the number of renumber of hours pebed equals x amount administrator stated there is a problem focus was to hire a had been the focus the administrator stated there is a problem focus was to hire a had been the focus the administrator stated there is a problem focus was to hire a had been the focus the administrator stated there is a problem focus was "no stone untuissue of the lack of necessary cares for 483.75(o)(1) QAA COMMITTEE-MEN QUARTERLY/PLAI	per, I think everybody g really good wash ups." on 10/26/15, at 4:24 p.m. the d staff had voiced concerns to ack of staffing and, "They eople", to help complete e facility staffing was on the size of the building, and d many residents who required istance for cares. The facility are down in resident census, (total number of hours divided esidents) to determine the er resident, so being down one ant of dollars." The d he had "certainly identified with lack of staffing, and the nd recruit new staff stating it is, "For a long time." Further, tated the facility had "used uit more staff, and he felt there are staffing to provide the residents. MBERS/MEET NS Intain a quality assessment and the consisting of the director of physician designated by the staff and assurance ment and assurance	F 4			12/29/15	
	necessary cares fo 483.75(o)(1) QAA COMMITTEE-MEN QUARTERLY/PLAI A facility must mair assurance committ nursing services; a facility; and at least facility's staff. The quality assessi	r the residents. MBERS/MEET NS Itain a quality assessment and ree consisting of the director of physician designated by the residue of the members of the	F 5	.20		12/29/15	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	26/2015	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 520	and assurance accidevelops and impleaction to correct ic. A State or the Sec disclosure of the recept insofar as a compliance of succept insofar and correct quality a basis for sanction. This REQUIREME by: Based on observatives, the facility assurance (QA&A and implement accept insofar and services assessed needs, from the facility of careful in the facility. Findings include: Refer to F242; The bathing preference reviewed for bathing preference reviewed for bathing include: Refer to F244; The sand in the potential	et to which quality assessment tivities are necessary; and ements appropriate plans of lentified quality deficiencies. Cretary may not require ecords of such committee such disclosure is related to the h committee with the is section. Its by the committee to identify deficiencies will not be used as ns. ENT is not met as evidenced ation, interview and document squality assessment and committee failed to develop tion plans to address identified, ns of inadequate staffing residents were provided with in accordance with their or 13 of 42 residents (R126, 45, R35. R21, R5, R64, R55, 23) reviewed for compliance e and quality of life regulations. It is facility failed to honor tes for 1 of 3 residents (R73)	F 5	F520-F Facility timely submits this replan of correction pursuant to state law requirements. This and plan of correction are not an agreement that a deficient exist or that a statement of a was correctly cited or factual it's not to be construed as an against interest of the facility administrator, of any employ or other individuals who part drafting or who may be discontent of the same and the policy of Lake Ridge to have a Quality Assessme Assurance Committee that of implements appropriate plant correct identified quality defined.	to federal and s response of admissions beincy does a deficiency lly based and n admission y, the yees, agents ticipated in the ussed or e. Care Center nt and develops and ns of action to		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

/26/2015
(X5) COMPLETION DATE
t i.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION		E SURVEY PLETED	
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
IAVEDI	DGE CARE CENTER	OE BUEEALO		3	10 LAKE BOULEVARD		
LANE NI	DGE CARE CENTER	OF BUFFALO		В	UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	OT-K, COTA-J, SM expressed concerninsufficient staffing had potential to affivisitors in the facility. On 10/26/15, at 5:0 (DON) was intervied QA&A committee. Committee gathere in effort to identify within the facility. Sincluded care conferons, verbal and/offamily/ residents, reand the on-going repast survey results the committee had that all residents are were asked at each facility was meeting felt they had been to concerns were precommittee. When of a quality deficier identified, providing action plans, the Dare just stuck on the other evils." She make that a QA thi HR [human resour retain good staff." almost everything everything tied into it [staffing many things that we enough people on the QA&A committed facility's staffing she	M-A and SM-B) interviewed who as and complaints related to . This lack of sufficient staff ect all 48 residents, staff and	F 5	520	Assessment Committee will meet quarterly to determine compliance regarding action plan areas. Administrator will monitor Quality Assurance and Assessment Commaction plan. 5.Those responsible to maintain compliance will be: Administrator is responsible for compliance.	nittee	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245513	B. WING _		10	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 520	stated, the facility's actually developed to address the state however, she state have done." The I management had implemented signit to be flexible with a the facility's staffingend of Summer, we college. She added who had left on ma DON confirmed the admissions, but standingsions until laresident discharge facility's QA&A con addressed concerneceiving baths or "This is one of the we were doing gre of September We aide [but] have not think everybody is	s QA&A committee had not or implemented an action planifing concerns within the facility. ed, "We report to QA what we	F 52	20		

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 20 20		
		00714	B. WING		10/26/2015
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment that was violated during corrected.	ther a violation has been impliance with all ule provided at the tag number indicated below. several items, failure to exitems will be considered tack of compliance upon a item of multi-part rule will ent of a fine even if the item ing the initial inspection was earing on any assessments			
	orders provided that a	non-compliance with these a written request is made to a 15 days of receipt of a for non-compliance			
	INITIAL COMMENTS You have agreed to p receipt of State licens the Minnesota Depart Informational Bulletin	: articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/27/15 **Electronically Signed**

TITLE

Minnesota Department of Health

STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURV	
		00714	B. WING		10/26/2	2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
	Т	BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE ((X5) COMPLETE DATE
2 000	Continued From page	e 1	2 000			
2 000	Department of Health you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department On October 19th, 20 26th 2015, surveyors visited the above procorrection orders are complaint investigation or eviewed these order they will be completed Minnesota Department the State Licensing Confederal software. Tag assigned to Minnesota Nursing Homes. The assigned tag nur column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Followi	orders being submitted to though no plan of correction a Statutes/Rules, please cted" in the box available for indicate in the electronic iss, under the heading date your orders will be ctronically submitting to the int of Health. Ith, 21st, 22nd, 23rd and of this Department's staff, wider and the following issued. In addition, a in was completed for antiated. Please indicate in information or correction that you have is, and identify the date when id. Int of Health is documenting correction Orders using numbers have been a state statutes/rules for	2 000			
	Time period for Corre PLEASE DISREGAR FOURTH COLUMN V	D THE HEADING OF THE				

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 2 of 105

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	
				_			
		00714		B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO		BOULEVARD MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION))	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From page	2		2 000			
	APPLIES TO FEDER THIS WILL APPEAR THERE IS NO REQU	IREMENT TO SUBMIT A ION FOR VIOLATIONS C	,				
2 130	MN Rule 4658.0050 S duties	Subp. 1 Licensee;General		2 130			12/29/15
	nursing home is respondential, and operation managed, controlled, that enables it to use efficiently to attain or	mental, and psychosocial	e r	3			
	by: Based on interview at facility failed to ensure assessed and develo inadequate staffing in during the recertificati	t is not met as evidenced and document review, the e administration effectively ped a plan to address the the facility as identified ion survey. This had 48 residents residing in the	y	•	Corrected.		
	Findings include:						
	the required assistant (R126) reviewed for contractions of the contraction of the contrac	ensure residents received	3,				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 3 of 105

Minnesot	a Department of Health	1			
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
I AKE RID	GE CARE CENTER OF E	310 LAKE	BOULEVARD		
LAKE KID	OE OAKE GENTER OF E	BUFFALO	D, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 130	Continued From page	3	2 130		
	R35 and R21) review 1 of 4 residents (R120 ulcers, for 1 of 3 residental hygiene, and 1 R64, R45, R19, and F of daily living (ADLs). residents (R126, R55 R123, and R27), 2 of FM-H), and 13 of 13 s NA-I, NA-C, NA-T, NA OT-K, COTA-J, SM-A expressed concerns a insufficient staffing. Thad potential to affect visitors in the facility. During interview on 1 nursing assistant (NA facility needed more swith cares. NA-G stated the schedinal care, shaving) is because of the lack of don't have enough timesidents." NA-G statinjured attempting to by themselves becaustaff on to help us out administration tells stabut rarely help staff prensure they are being administration revised responsibility. During interview on 1	ted several staff had been care for two assist residents se, "There's not enough" NA-G stated the facility aff they, "Are looking into it," rovide the resident cares to g completed, nor have the			

Minnesota Department of Health

had been short staffed lately. The lack of staff

STATE FORM 6899 28WI11 If continuation sheet 4 of 105

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLI	
		00714	B. WING		10/2	6/2015
NAME OF D	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	NOVIDEN ON 301 1 EIEN		BOULEVARD	TIE, ZII GODE		
LAKE RID	GE CARE CENTER OF B	BUFFALO	, MN 55313			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				,		
2 130	Continued From page	2 4	2 130			
	had made residents h	ave to wait for help for				
	extended periods, and	d HA-A will often walk by				
		ents asking, "Help me, help				
		Iministration is aware of the				
		ble to assist residents with				
	add more staff, "But it	nployees they are trying to				
	add more stair, but it	takes line.				
	During interview on 1	0/22/15, at 1:53 p.m. NA-T				
	_	short staffed and resident				
		a result. There had been	,			
	· ·	NA on each hallway to care				
		st, and when that occurs "Just wait," to receive care				
		stated the bathing and				
		s had suffered, "Lots of				
		e poor staffing and the cares				
	are not able to be con	npleted. NA-T stated the				
		meeting a few months ago				
		d about solutions to short				
		hing had been done to aff to ensure resident cares				
		d administration had not				
		what is being done to meet				
	the needs of the resid	<u> </u>				
		0/22/15, at 2:20 p.m. NA-K				
		acility was, "Absolutely t care was suffering. NA-K				
	-	uently not even a nurse				
		nit (an end-of-life care unit),				
		wait for long periods of time				
		answered because "We				
		," to answer them. The				
		ne nothing to help with				
		t the floor staff to get the				
		ome onto the floor when you				
	guys [state surveyors]	j ale liele.				
	During interview on 10	0/23/15, at 11:52 a.m.				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 5 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00714	B. WING		10/26/2015
				10/26/2015
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUI	FFALO BUFFALO,	BOULEVARD MN 55313		
OVA ID SUMMADV STATE	EMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d over
PREFIX (EACH DEFICIENCY N	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 130 Continued From page 5	j	2 130		
registered nurse (RN)-A a "big issue" at the facili short of help and the res being completed as ass several staff had resign staffing, and administrat staff about changing ho better, or asked the resi how to handle the short During an anonymous in member (SM)-A, severa with concerns about the SM-A stated the staffing and administration was work the past few days, surveyors] are here." S home after their shift an were unable to complete the residents, "The care SM-A stated several bar recent shift, but only two becasue there was not the cares, and SM-A wa nursing (DON) to sign th they were completed, at there was not enough s SM-A stated that made stated administration he floor was not typical, an this week, "Because you are here."	A stated staffing had been ity. The floor staff are sidents care was not sessed. RN-A stated ed because of the poor tion had never asked the urs to balance the work igning floor staff's input on staffing situation. Interview with a staff al issues were presented elack of staff in the facility, pulling in extra staff to "Because you guys [state M-A stated they often go and feel bad because they be their jobs and care for es are just not good." Ith were scheduled for a coof them were completed enough staff to provide the staff to provide the bathing. The care sheets identifying lithough DON was aware taff to provide the bathing. The care sheets identifying lithough DON was aware taff to provide the bathing. The care sheets identifying lithough guys [state surveyors] Interview, SM-B stated, cause of the staffing," and some shifts with only two or to work and care for the they spoke to	2 130		

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 6 of 105

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
			D WING			
		00714	B. WING		10/26/201	15
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
I AKE RIC	GE CARE CENTER OF E	SUFFALO 310 LAKE	BOULEVARD			
	OL OAKE GENTER OF E	BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COI	(X5) MPLETE DATE
2 130	Continued From page	e 6	2 130			
2 130	baths, and grooming however, nothing had staffing, and SM-B had how administration with the staffing, and SM-B had how administration with the staffing and staffing and staffing and staffing and staffing and staffing are tied. There are so many the issue if we had enoug DON confirmed facility aware of the facility's quality concerns resustaffing, however, the ongoing. The DON staffing shortage beging staffing shortage beging staffing shortage beging summer, when student well as eight facility staffing shortage beging summer, when student well as eight facility staffing shortage beging summer, when student well as eight facility staffing shortage beging summer, when student well as eight facility staffing shortage beging summer, when student well as eight facility staffing shortage beging summer, when student well as eight facility staffing shortage beging summer, when student well as eight facility staffing shortage beging staffing shortage beging staffing shortage beging staffing shortage beging staffing staffing shortage beging staffing shortage staff	because of the lack of staff, been done to fix the lack of ad heard nothing further on all resolve this. p.m. DON stated, "Right on the staffing [lack of]. It other evils." She stated, ate HR [human resources] and retain good staff." The hat almost everything else as potential quality into it [staffing concerns] ings that would not be an hap people on the floor." The y management was well staffing shortage and the liting from insufficient concern of lack of staff is ated facility management huses, implemented pay, and tried to be flexible . She stated the facility's an around the end of outs returned to college, as taff who left on maternity firmed the facility was still sions, and stated she was as of residents who were not all cares, and, "This is one of to staffing. We are ath aide [but] have not had , I think everybody eally good wash ups." 10/26/15, at 4:24 p.m. the the staffing was determined the building, and if they	2 130			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 7 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00714	B. WING		10/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ITE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
			D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ГЕ
2 130	Continued From page	e 7	2 130			
	did cut hours if they a and use a formula (to by the number of resi number of hours per bed equals x amount administrator stated had been the focus, "the administrator state everything" to recruit was "no stone unturn issue of the lack of st necessary cares for the SUGGESTED METH. The facility administrator reprocedures related to administration. Resp re-educated on these	are down in resident census, stal number of hours divided dents) to determine the resident, so being down one of dollars." The ne had "certainly identified ith lack of staffing, and the recruit new staff stating it "For a long time." Further, ed the facility had "used more staff, and he felt there ed" in trying to address the affing to provide the				
2 255	MN Rule 4658.0070 (Assurance Committee	Quality Assessment and e	2 255		12/29/15	5
	of the administrator, t services, the medical designated by the me three other members representing disciplin resident care. The quassurance committee	urance committee consisting the director of nursing director or other physician edical director, and at least of the nursing home's staff, es directly involved in uality assessment and must identify issues with ity assurance activities are				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 8 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:	
		00714	B. WING		10/26/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 255	Continued From page	e 8	2 255		
	quality deficiencies. address, at a minimur reporting, infection copharmacy services. This MN Requirement by: Based on observation review, the facility's quasurance (QA&A) cound implement action systematic concerns patterns to ensure rescare and services in a assessed needs, for R73, R27, R19, R45, R85, R118 and R123 with quality of care ar	m, incident and accident introl, and medications and it is not met as evidenced in, interview and document uality assessment and infinite failed to develop plans to address identified, of inadequate staffing sidents were provided with		Corrected.	
	Findings include:		•		
	*Refer to F244: The prompt responses to staffing concerns. The 5 of the 48 residents	or 1 of 3 residents (R73) choices. facility failed to ensure grievances related to is had the potential to affect (R27, R19, R45, R35 and tended resident council			
	appropriate incontine necessary and failed a pressure relieving w directed by the writter	facility failed to provide noce products when to ensure appropriate use of wheelchair cushion, as a plan of care, for 1 of 4 ewed for pressure ulcers.			

6899

Minnesota Department of Health STATE FORM

28WI11 If continuation sheet 9 of 105

Minnesota Department of Health

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			VEY ED
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) 310 LAKE BOULEVARD BUFFALO, MN 55313 ID PROVIDER'S PLAN OF CORRECTION (X COMPREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPREMENTATION OF			00714	B. WING		10/26/2	2015
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 (X4) ID	NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	LAKE RIDO	GE CARE CENTER OF E	BUFFALO				
	PRÉFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETE DATE
2 255 Continued From page 9 2 255	2 255	Continued From page	9	2 255			
The facility also failed to provide oral cares as directed by the care plan for 1 of 3 residents (R5) reviewed for dental hygiene. *Refer to F312: The facility failed to ensure nail care was completed for 2 of 5 residents (R5, R64), bathing completed for 2 of 5 fesidents (R5, R64), bathing completed for 2 of 5 fesidents (R5, R64), bathing completed for 2 of 5 fesidents (R5, R64), bathing completed for 2 of 5 fesidents (R5, R64), bathing completed for 2 of 5 fesidents (R712) reviewed for activities of daily living (ADLs) and who were dependant on staff for their care. *Refer to F353: The facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 2 residents (R126) reviewed for dignified care and services, for 1 of 3 residents (R713) reviewed for proug grievances, for 1 of 3 residents (R713) reviewed for proug grievances, for 1 of 4 residents (R126) reviewed for proug grievances, for 1 of 4 residents (R126) reviewed for prossure ulcers, for 1 of 3 residents (R5), reviewed for daily living (ADLs). In addition, for 9 of 9 residents (R126, R55, R85, R118, R8, R73, R35, R123, and R27), 2 of 4 family members (RM-G, FK-A, NA-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, OT-K, COTA-J, SM-A and SM-B) interviewed who expressed concerns and complaints related to insufficient staffing. This lack of sufficient stafff had potential to affect all 48 residents, staff and visitors in the facility. On 10/26/15, at 5:06 p.m. the director of nursing (DON) was interviewed regarding the facility's QA&A committee. The DON reported the QA&A committee gathered data from numerous sources in effot to identify potential quality deficients	2 255	The facility also failed directed by the care previewed for dental hy *Refer to F312: The facare was completed f R64), bathing comple (R45, R19), and assis provided for 1 of 5 resactivities of daily living dependant on staff for the required assistance (R126) reviewed for a for 1 of 3 residents (R126) reviewed for 1 of 3 residents (R126) reviewed for 1 of 4 residents (R126) ulcers, for 5 of the 4 R35 and R21) reviewed 1 of 4 residents (R126) ulcers, for 1 of 3 residental hygiene, and R64, R45, R19, and	I to provide oral cares as plan for 1 of 3 residents (R5) ygiene. acility failed to ensure nail for 2 of 5 residents (R5, sted for 2 of 5 residents stance with toileting was sidents (R126) reviewed for g (ADLs) and who were residents received the for 1 of 2 residents lignified care and services, (R73) reviewed for bathing residents (R27, R19, R45, red for group grievances, for 6) reviewed for pressure lents (R5) reviewed for activities In addition, for 9 of 9, R85, R118, R5, R73, R35, 4 family members (R4, R4, R4, R4, R4, R4, R4, R4, R4, R4,	2 255			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 10 of 105

Minnesot	a Department of Health	1			FURIV	IAPPROVED
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			7 50.25			
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
I AKE DID	GE CARE CENTER OF E	310 LAKE	BOULEVARD			
LAKE KIL	OL CARL CLIVILIC OF L	BUFFALO	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 255	Continued From page	: 10	2 255			
	included care confered forms, verbal and/or of family/ residents, residents and the on-going revipast survey results on the committee had identified that all residents and/were asked at each of facility was meeting the felt they had been treconcerns were preserd committee. When as of a quality deficiency identified, providing a action plans, the DON are just stuck on the state other evils." She make that a QA thing HR [human resources retain good staff." The almost everything elstied into it [staffing comany things that wou enough people on the the QA&A committee facility's staffing short concerns resulting frostated, the facility's Q actually developed or to address the staffing However, she stated, have done." The DO management had offeimplemented significat to be flexible with shift the facility's staffing s	nce reports, facility concern written reports from staff/ dent satisfaction surveys ew of audit results, from other quality deficiencies entified. The DON reported or their representatives are conference whether the neir needs and whether they ated well. Any identified of the QA&A ked to provide an example the committee had description of any resulting a reported, "Right now we staffing. It is the driver of all stated, "I don't know how to We work with corporate estail the time to get and the DON added, "I think that the that we've identified are neerns] There are so ald not be an issue if we had a floor." The DON confirmed was well aware of the lage and the quality m insufficient staffing. She A&A committee had not implemented an action plan of concerns within the facility. "We report to QA what we N stated facility				

Minnesota Department of Health

college. She added, there were eight facility staff who had left on maternity leave as well. The DON confirmed the facility was still accepting new

STATE FORM 28WI11 If continuation sheet 11 of 105

Minnesota Department of Health

IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
00714	B. WING		10/2	6/2015
		TE, ZIP CODE		
OF BUFFALO				
IENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
tated they had delayed some ater in the week when another ed. When asked whether the ammittee had identified or ans of residents who were not a roral cares, she responded, things that is tied to staffing eat until the first or second week we are supposed to have a bath of had one since September It is getting really good wash ups." garding the responsibilities of the was requested, but was not etcor, facility administrator and/or goould review and/or revise did procedures related to the the Quality Assessment & ittee. Responsible personnel ated on these policies and diffied quality deficiencies could evaluated for action plans.	2 255			
Status nust develop and implement staff decisions to consult cian assistants, and nurse if known, notify the resident's ve or an interested family	2 265			12/29/15
TROY IN SINCE DISTRICT BOOKING ON THE SINCE IN SINCE IN THE RESERVE OF THE SINCE IN	OF BUFFALO RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) page 11 stated they had delayed some later in the week when another yed. When asked whether the committee had identified or erns of residents who were not or oral cares, she responded, the things that is tied to staffing reat until the first or second week We are supposed to have a bath of had one since September I ties getting really good wash ups." regarding the responsibilities of tittee was requested, but was not ETHOD OF CORRECTION: ctor, facility administrator and/or tig could review and/or revise and procedures related to the fifthe Quality Assessment & nittee. Responsible personnel tated on these policies and ntified quality deficiencies could did evaluated for action plans. OR CORRECTION: Thirty (30) OBS Notification of Chg in Status must develop and implement staff decisions to consult ician assistants, and nurse did known, notify the resident's tive or an interested family ident's acute illness, serious	STREET ADDRESS, CITY, STA OF BUFFALO OF BUFFALO OF BUFFALO BUFFALO, MN 55313 RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) Page 11 Stated they had delayed some later in the week when another ged. When asked whether the ommittee had identified or erms of residents who were not or oral cares, she responded, ethings that is tied to staffing reat until the first or second week We are supposed to have a bath of had one since September I is getting really good wash ups." RETHOD OF CORRECTION: Cotor, facility administrator and/or go could review and/or revise and procedures related to the fithe Quality Assessment & nittee. Responsible personnel lated on these policies and notified quality deficiencies could devaluated for action plans. OR CORRECTION: Thirty (30) DASS Notification of Chg in Status must develop and implement staff decisions to consult ician assistants, and nurse dif known, notify the resident's cive or an interested family ident's acute illness, serious	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313 PRY STATEMENT OF DEFICIENCIES JEINCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) PAGE AND ADDRESS AND ADDRESS AND ADDRESS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPP DEFICIENCY) PAGE AND ADDRESS AND ADDRESS AND ADDRESS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPP DEFICIENCY) PAGE IN THE ADDRESS AND ADDRESS AND ADDRESS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPP DEFICIENCY) PAGE IN THE ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPP DEFICIENCY) PAGE IN THE ADDRESS AND ADDRESS	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO BUFFALO BUFFALO BUFFALO BUFFALO, MN 55313 RY STATEMENT OF DEFICIENCIES JENCY MUST BE PRECEDED BY FULL YOR LSC IDNIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY) page 11 2 2 255 stated they had delayed some later in the week when another later in the state of the staffing reat until the first or second week We are supposed to have a path of had one since September I is getting really good wash ups." later and the preparation of the preparation

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 12 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		D.	X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00714	Е	B. WING		10	/26/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STAT	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	310 LAKE BO BUFFALO, MI	_			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 265	attending physician in development of these have criteria which are appropriate notification. A. an accident in results in injury and his physician intervention. B. a significant complete physical, mental, or example, a deterioral psychosocial status in conditions or clinical. C. a need to alte example, a need to do freatment due to a begin a new form of the properties of the properties. D. a decision to resident from the number of the properties of the	I the medical director or nust be involved in the expolicies. The policies of directs at least the contimes for: volving the resident which has the potential for require, thange in the resident's psychosocial status, for the complications; In treatment significantly, iscontinue an existing for diverse consequences, correatment; It transfer or discharge the sing home; or unexpected resident dent is not met as evidence the interview and docume the discontinue and docume the	an must chairing for orm or to e aths. ed ent al R45)	2 265	Corrected.		

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 13 of 105

STATEMENT	<u>a Department of Healtr</u> FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD O, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 265	Continued From page	: 13	2 265		
	Report dated 4/20/15 subcutaneous once in An Allina Health office indicated under "Your units at bedtime. R45's Diabetic Admin 4/30/15, indicated Lar morning with a start of HS (at bed time), with Diabetic Administratic R45 received Lantus to 4/26/15. The Buffalo Clinic Tele 4/8/15, indicated at 8: Lake Ridge care cent today, and told per or Per the Buffalo Clinic dated 4/27/15, Dr. An p.m., "Discussed with 4/20/15 visit, had writ units at bedtime wher daily MORNING DOS patient has been recedally since the last vis sugars." Dr. Andersor units once daily in the stay. Lake Ridge Care Center of the stay.	e visit note dated 4/20/15, Plan" back on lantus 37 istration History 4/1/15, to ntus 37 units once in ate of 4/17/15 and Lantus at a start date of 4/20/15. The n History report indicated 37 units at HS from 4/20/15 ephone order report dated 58 a.m. received call from er, had blood sugar of 67 ders to call if below 80. Telephone order report derson indicated at 5:34 (staff) by phone. As of ten to return to Lantus 37 in it should have been once it > Clarified with (staff) siving lantus 37 units twice sit with recent low blood in then ordered Lantus 37 is morning as prior to hospital			
	on 4/22/15, at 7:44 a. only 52 mg/dl (milligra	m. R45 blood glucose was ams per deciliter). Review of d not indicate the physician			

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 14 of 105

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER B. WING 10/26/20 OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	 		IDENTIFICATION NUMBER:	OF CORRECTION	AND FLAN
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	10/26/2015	3	00714		
	DDE	TY, STAT	STREET ADDR	PROVIDER OR SUPPLIER	NAME OF PI
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO MN 55242			BUFFALO	OGE CARE CENTER OF E	LAKE RID
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE CROSS-REFERENCED TO THE APPROPRIATE DATE) FIX	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PRÉFIX
2 265 Continued From page 14 2 265		,	e 14	Continued From page	2 265
Resident Progress Note dated 4/25/15, indicated a blood sugar was only 51 while R45 was eating her breakfast meal. Review of the medical record did not indicate the physician was notified of the low blood sugar. Resident Progress Note dated 4/26/15, at 3:30 a.m. blood sugar of 51. Review of the medical record did not indicate the physician was notified of the low blood sugar of 51. Review of the medical record did not indicate the physician was notified of the low blood glucose. Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated "Resident had low BS (blood sugar) this morning was sweating and shaky, she had a BS of 38. The physician was called at 8:44 a.m." Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated "Resident had been receiving Lantus 37 units BID (twice a day) since 4/20, miscommunication written upon return from appointment. Spoke with Dr. Anderson and the HS dose has been dic'd (discontinued) and will continue the 37 units in AM.* During interview 10/26/15, at 9:30 a.m. with the DON who stated she was not aware of the insulin discrepancy and stated she was unable to locate a medication error. The DON further stated the nurses should have called the physician when they noted the order for Lantus to be given at HS since she was not on that before and because of her low blood sugars. Although R45 had an order to notify the physician if blood sugars were below 80, the facility did not notify the physician of the three low blood sugars. The facility's Change in Resident's Condition Or Status policy dated 7/14, directed "POLICY; It is			ote dated 4/25/15, indicated ly 51 while R45 was eating deview of the medical record hysician was notified of the ote dated 4/26/15, at 3:30 1. Review of the medical enthe physician was notified ose. Ote dated 4/27/15, at 8:33 ent had low BS (blood as sweating and shaky, she ohysician was called at 8:44 ote dated 4/27/15, at 5:37 ent had been receiving twice a day) since 4/20, ritten upon return from with Dr. Anderson and the c'd (discontinued) and will in AM." 6/15, at 9:30 a.m. with the was not aware of the insulined she was unable to locate the DON further stated the alled the physician when for Lantus to be given at HS that before and because of order to notify the physician below 80, the facility did not at the three low blood sugars.	Resident Progress No a blood sugar was on her breakfast meal. R did not indicate the plow blood sugar. Resident Progress No a.m. blood sugar of 5 record did not indicate of the low blood gluco Resident Progress No a.m. indicated "Resid sugar) this morning whad a BS of 38. The pa.m." Resident Progress No p.m. indicated "Resid Lantus 37 units BID (miscommunication with a proposition of the state of the st	2 205

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 15 of 105

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF PF	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
		BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 265	Continued From page	e 15	2 265			
	resident, his or her At representatives of chamedical/mental conditions and conditions and/or revise facility prelated to physician in personnel could be reand procedures. Approached to the physician identified in the deficit documentation maintacould be evaluated for notifications. An audi developed and implementation maintacould be evaluated for notifications. An audi developed and implementation maintacould be evaluated for notifications. An audi developed and implementation maintacould be evaluated for notifications. An audi developed and implementation maintacould be evaluated for notifications. An audi developed and implementation maintacould be evaluated for notifications.	OD OF CORRECTION: g or designee, could review policies and procedures otification. Responsible e-educated on these policies propriate notices could be n's of the individual(s) ency, with supporting pained. Other residents or appropriate physician ting system could be mented, with results shared lity Assessment &				
	(14) days.		,			
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			12/29/15
		nprehensive plan of care ersonnel involved in the				
	by: Based on observation	t is not met as evidenced n, interview and document ed to provide oral cares as		Corrected.		

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 16 of 105

Minnesota Department of Health

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		
		00714	B. WING		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD , MN 55313			
040.15	CLIMMADV CT		·	DROVIDED'S DI AN OE CODDECTIO	N OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
2 565	Continued From page	e 16	2 565			
	directed by the care previewed for dental hy	olan for 1 of 3 residents (R5) ygiene.				
	Findings include:	•				
	9/15/15, identified R5 required extensive as hygiene, including bru During observation or was seated in a reclir showed he had sever	Im Data Set (MDS) dated had intact cognition, and sistance with personal ushing his teeth. In 10/20/15, at 9:16 a.m. R5 her chair in his room, and hal missing teeth on his eked about his oral health.				
	R5's care plan dated an, "Alteration in ADL dressing, grooming a care plan directed stacare am [morning] and During interview on 1 stated the care plan is [staff] supposed to do NA-F helped R5 get roffer or assist him to Further, NA-F stated having his teeth brush	7/14/15, identified R5 had s [activities of daily living] of nd bathing". Further, the iff to assist R5 with, "Oral d pm [evening]" 0/23/15, at 12:55 p.m. NA-F is used to know "what we're is for the residents care. eady for the day, but did not				
	When interviewed on stated R5 needs to be complete oral cares,	10/23/15, at 1:04 p.m. RN-A e set up with assistance to and NA-F should have , "That's what should be				
	A facility policy regard implementation was r provided.	ling care plan equested, but was not				

Minnesota Department of Health STATE FORM

STATE FORM 28WI11 If continuation sheet 17 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
		00714	B. WING		10/2	26/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	310 LAKE I BUFFALO,	BOULEVARD MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	Continued From page	e 17	2 565			
	SUGGESTED METH The director of nursin and/or revise facility prelated to implementa Responsible personn these policies and proservices for the individence of their written plan of cabe evaluated for care auditing system could implemented, with resulting system could implemented, with resulting system could implemented, with resulting assessment 8 ensure on-going com TIME PERIOD FOR 0 one (21) days. MN Rule 4658.0510 Staffing requirements Subpart 1. Staffing rehome must have on conumber of qualified registered nurses, lice nursing assistants to residents at all nurses in all buildings if more	OD OF CORRECTION: g or designee, could review policies and procedures atton of resident care plans. Hele could be re-educated on pocedures. Care and dual(s) identified in the conitored for compliance with are. Other residents could plan implementation. An all be developed and sults shared with the facility's Assurance committee, to pliance. CORRECTION: Twenty- Bubp. 1 Nursing Personnel; Requirements. A nursing luty at all times a sufficient pursing personnel, including tensed practical nurses, and the meets of the stations, on all floors, and than one building is es relief duty, weekends,	2 800			12/29/15
	by: Based on observation review, the facility fail staffing to ensure resi	t is not met as evidenced n, interview, and document ed to provide adequate dents received the required for 1 of 2 residents (R126)		Corrected.		

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 18 of 105

Minnesota Department of Health

Minnesot	a Department of Health					
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	ILED
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AN	DRESS, CITY, STA	ATE ZIP CODE		
NAME OF T	NOVIDER OR OUT FEEL		BOULEVARD	(IL, ZII OODL		
LAKE RID	GE CARE CENTER OF E	BUFFALO	, MN 55313			
			, IVIN 55515			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
2 800	Continued From page	e 18	2 800			
	ravioused for dignified	care and services, for 1 of 3				
	_	wed for bathing choices, for				
	, ,	(R27, R19, R45, R35 and				
		oup grievances, 1 of 3				
		red for dental hygiene, and				
	for 5 of 6 residents (R	R5, R64, R45, R19, and				
	R126) reviewed for a	ctivities of daily living				
		for 9 of 9 residents (R126,				
		R73, R35, R123, and R27),				
		s (FM-G, FM-H), and 13 of				
	NA-T, NA-K, LPN-F, I	A-G, HK-A, NA-I, NA-C,	,			
		M-B) interviewed expressed				
	1	ints related to insufficient				
		sufficient staff had potential				
	_	nts who currently resided in				
	the facility.					
	Findings include:					
	ACCECCED DECIDE	NT NEEDS NOT DEING				
	MET:	NT NEEDS NOT BEING				
	IVIL I.					
	*Refer to F242: The	facility failed to honor				
		for 1 of 3 residents (R73)				
	reviewed for bathing	choices.				
		facility failed to ensure				
	prompt responses to					
	_	nis had the potential to affect				
		(R27, R19, R45, R35 and ttended resident council				
	meetings from 7/28/1					
		0.00 0.20110.				
	*Refer to F282: The	facility failed to provide oral				
		the care plan for 1 of 3				
	residents (R5) review	ed for dental hygiene.				
		acility failed to ensure nail				
	care was completed f	for 2 of 5 residents (R5,				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 19 of 105

Minnesota Department of Health

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD		
	OLIMAN DV OT		, MN 55313	DROWDERIO DI AM OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 800	Continued From page	e 19	2 800		
2 800	R64), bathing complet (R45, R19), and assist provided for 1 of 5 restricted for 1 of 5 r	sted for 2 of 5 residents stance with toileting was sidents (R126) reviewed for g (ADLs) and who were r their care. RNS ABOUT STAFFING: Inimum Data Set (MDS) ided R126 had intact ed extensive assistance to a development of the total conditions as in the enceded staff assistance to get into his wheelchair, and ong it would take staff to and that made him feel, ess." During a follow-up is, at 10:00 a.m. R126 stated to use a commode for dpan. However, due to long ften utilized a bedpan. He to get on and off the one of the public to get onto the commode it for staff to help. R126 we much rather used a	2 800		
	R55 had moderate co	dated 9/15/15, identified ognitive impairment, and tance from staff for ADLs.			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 20 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			D WING		
		00714	B. WING		10/26/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO BUFFALO,	BOULEVARD MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 800	Continued From page	e 20	2 800		
	stated she often had time to get help to the frequently incontinent long. R55 stated the help residents with th have the people to work. R85's quarterly MDS had intact cognition, a assistance from staff. During interview on 1 stated the facility had the past two or three takes, "Quite awhile"	t because of waiting for so efacility needed more staff to eir cares, "They just don't ork." dated 9/1/15, identified R85 and required extensive			
		OS dated 8/24/15, identified ition, and required limited to complete ADLs.			
	stated staffing seems in the evenings. R11 that needed to be cor resident had to wait o	ver 6 hours for staff to aused the dressing to			
	had intact cognition, a assistance from staff				
	During interview on 1	0/20/15, at 9:11 a.m. R5			

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 21 of 105

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 20.25.110.		
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD , MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 800	staff would often comstaffed to him, and at was only one nurse with R5 stated his call light minutes," to get answer the commode for, "Ar staff came to provide R73's admission MDS R73 had intact cognition assistance from staff During interview on 1 stated he had waited past for staff assistant call light to be answer over worked and und to be provided the network worked and und to be provided the network worked and und to be provided the network and moderate correquired extensive as complete ADLs. During interview on 1 stated the facility staff the time, and there has have to wait to use the incontinent due to not from staff to get to the R123's admission ME	not have enough staff, and plain about being short times R5 had stated there vorking for an entire shift. It will take, "Fifteen to twenty tered, and was once left on a hour and a half," before assistance. So dated 10/1/15, identified ion, and required extensive to complete ADLs. 10/21/15, at 10:55 a.m. R73 for nearly two hours in the ce to go to bed and for his red. R73 stated the staff are er staffed for the residents cessary cares in the facility. 10/20/15, at 10:29 a.m. R35 for worked short nearly all of ad been times R35 would be bathroom but was a receiving timely assistance are restroom. 10/20/20/20/20/20/20/20/20/20/20/20/20/20	2 800	DETICIENCI	
	During interview on 1	0/20/15, at 12:20 p.m. R123			

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 22 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/26/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	SUFFALO 310 LAKE I BUFFALO,	BOULEVARD MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 800	Continued From page	22	2 800		
	to the restroom, caus diaper," which she stated degraded." R27's quarterly MDS R27 had intact cognit assistance from staff During interview on 1 stated she had waited her call light answere the facility needed to the cares the resident	dated 9/22/15, identified ion, and required extensive to complete ADLs. 0/20/15, at 10:24 a.m. R27 d for over an hour to have d to receive assistance, and have more staff to provide its needed.			
	During interview on 1 member (FM)-G state family member in the requesting staff assis waited, and waited," of staff to respond. The occurrences of waiting answered, and FM-G response times] concurrences of they had been told that they were "Adequated disagreed and the fact staff to help residents." During interview on 1 stated he had noticed not being completed in	g for the call light to be stated, "It [long call light erns me." FM-G stated e owners of the facility felt y staffed," but stated she cility needed to add more with cares. 0/26/15, at 10:01 a.m. FM-H oral cares were frequently because of the lack of staff Il light had taken over one in the past, and was			

Minnesota Department of Health STATE FORM

STATE FORM 28WI11 If continuation sheet 23 of 105

Minnesota Department of Health

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S	
			A. BOILDING.			
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	UFFALO 310 LAKE I BUFFALO,	BOULEVARD MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 800	Continued From page	23	2 800			
	STAFF CONCERNS A During interview on 10 nursing assistant (NA facility needed more s with cares. NA-G stat complain about the lo and lack of assistance NA-G stated the sche (nail care, shaving) is because of the lack of don't have enough tim residents." NA-G stat injured attempting to o by themselves becaus staff on to help us out administration tells stat but rarely help staff pr ensure they are being During interview on 10 housekeeping aide (H had been short staffed had made residents h extended periods, and rooms and hear reside me." HA-A stated ad concerns staff is unab cares, but they tell em add more staff, "But it During interview on 10 stated the staffing at t and there was frequer lights were not answel lack of staffing, "They	ABOUT STAFFING: 0/22/15, at 10:38 a.m.)-G stated she felt the staff to assist the residents ted the residents often ing call light response time at they receive with cares. It duled baths and grooming not always completed if staffing adding, "[staff] in the totake care of the red several staff had been care for two assist residents are. "There's not enough." NA-G stated the facility aff they, "Are looking into it," rovide the resident cares to a completed. 0/22/15, at 10:53 a.m. IA)-A stated the nursing staff dilately. The lack of staff ave to wait for help for the HA-A will often walk by ents asking, "Help me, help ministration is aware of the ole to assist residents with aployees they are trying to				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 24 of 105

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD	
310 LAKE BOULEVARD	AME OF PROVIDER
LAKE RIDGE CARE CENTER OF BUFFALO	AKE RIDGE CA
BUFFALO, MN 55313	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COME TAG DEFICIENCY)	PREFIX
2 800 Continued From page 24 2 800	2 800 Conti
members were injured because they waited for help for so long, and nobody came, so they attempted to roll residents in bed by themselves. During interview on 10/22/15, at 1:36 p.m. NA-C stated the staffing was "awful," adding the facility was supposed to have six or seven NA's to care for the residents during the morning shift, but frequently is left with only four NA's. NA-C stated at times on the weekend there would be just two nurses and two NA's to care for all of the residents, and on that weekend, no residents received their scheduled bathing, and beds were not made because of the lack of staff. During interview on 10/22/15, at 1:53 p.m. NA-T stated the facility was short staffed and resident care was suffering as a result. There had been instances of only one NA on each hallway to care for residents in the past, and when that occurs the residents have to, "Just wait," to receive care and attention. NA-T stated the bathing and grooming of residents had suffered, "Lots of times," because of the poor staffing, NA-T stated the administration held a meeting a few months ago and talked about solutions to short staffing, however, nothing had been done to improve not having enough staff, and nothing further had been discussed. During interview on 10/22/15, at 2:20 p.m. NA-K stated staffing at the facility was, "Absolutely horrible," and resident care was suffering, NA-K stated there was frequently not even a nurse covering the Oasis unit (an end-of-life care unit), and residents had to wait for long periods of time to get their call lights answered because "We Istaff don't have time," to answer them. The	memli help f attem Durin stated was s for the frequency at time nurse reside received not members and a groom times the adappear and restated horrib stated cover and reto get

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 25 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	SUFFALO 310 LAKE BUFFALO,	BOULEVARD MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 800	you guys [state surver During interview on 1 licensed practical nur "Not adequate," to ca needs, and she was of facility because she wand felt it was being puthe lack of staffing an as a result. During interview on 1 stated she felt the facts at the fact of staffing and residents had to and families voice frur regarding the sufferin poor staffing. LPN-B dressing changes we nurse did not have tin trying to help provide other residents. During interview on 1 registered nurse (RN) a "big issue" at the fact short of help and the overall. RN-A stated because of the poor shad never asked the sto balance the work bestaff's input on how to situation. During interview on 1 occupational therapis therapist assistance (could use more help,	ome onto the floor, "When yors] are here." 0/22/15, at 2:53 p.m. se (LPN)-F stated staffing is re for the residents and their quitting her position at the alued her nursing license, but in jeopardy because of d poor care being delivered 0/23/15, at 7:07 a.m. LPN-B ility did not have enough accessary care to residents, wait to get up for the day, stration to the staff g care as a result of the stated she recalled some ren't completed because the ne because they were busy the necessary care for the 0/23/15, at 11:52 a.m. o-A stated staffing had been cility. The floor staff are residents care was suffering several staff had resigned staffing, and administration staff about changing hours etter, or asked for floor handle the short staffing	2 800		

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 26 of 105

Minnesota Department of Health

STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SI	
7.1.12 . 12.1.1	5. G5.11.126.11611	152111110711101111011152111	A. BUILDING: _		""	25
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
I AKE DID	GE CARE CENTER OF B	310 LAKE	BOULEVARD			
LAKE KID	GE CARE CENTER OF B	BUFFALO	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 800	Continued From page	26	2 800			
2 800	and waiting, "Way too answered. OT-K and aware of any actions address the short state." During an anonymous member (SM)-A, seve with concerns about to SM-A stated the staffi and administration was the past few days, "Be surveyors] are here." home after their shift were unable to complete the residents, "The cas SM-A stated several to recent shift, but only to and SM-A was told by (DON) to sign the car were completed. SM-"Really upset," and state with cares on the floo only being done, "becaurveyors] are here." During an anonymous "People are quitting be raised concerns about or three staff on the floresidents. SM-B state administration regard having enough staff to baths, and grooming	olong for [call] lights," to be OTA-J stated they were not being taken by the facility to fing concerns. Is interview with a staff eral issues were presented the lack of staff in the facility, as pulling in people to work ecause you guys [state SM-A stated they often go and feel bad because they ete their jobs and care for ares are just not good." Toaths were scheduled for a two of them were completed of the director of nursing e sheets identifying they. A stated that made her, ated administration helping in was not typical, and was eause you guys [state interview, SM-B stated, ecause of the staffing," and it some shifts with only two poor to work and care for the	2 800			
	documents, which dis staff working on the fl	ke Ridge Care Center) played the names of the oor for each shift, dated , were reviewed. The ach unit of the facility				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 27 of 105

Minnesot	<u>a Department of Health</u>	:h			
	OF DEFICIENCIES			CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00744	B. WING		40/00/0045
		00714	B. W		10/26/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE	
		310 LAF	E BOULEVARD		
LAKE RID	GE CARE CENTER OF E	BUFFALO BUFFAL	.O, MN 55313		
()(4) ID	SLIMMADV ST.	FATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
2 800	Continued From page	a 27	2 800		
2 000	. •		2 000		
	(Oasis, Lake View La	ane, Mill Creek Bridge, and			
	Northwoods), and pro	ovided blank spaces in which			
	a staff members nam	ne was written to identify			
	were they were sched	duled to work.			
	> On the AM shift, 10	0/19/15, the Oasis unit had			
	no staff names identif	fied as being assigned to			
	work on the unit. Mill	I Creek Bridge and			
	Northwoods each had	d open spaces identifying no			
		to work; and were left with			
		ne NA for each unit. The			
	document identified s	six of the thirteen spaces			
	used to identify staff,	to be blank.			
	•				
	> On the AM shift, 10	0/20/15, the Oasis unit again			
	had no staff names id	dentified as being assigned			
	to work on the unit. N	Mill Creek Bridge and			
	Northwoods had oper	n spaces with no staff			
	names written in. Bot	oth units continued with just			
	one nurse, and one N	NA working on the floor		\ \ \ \	
	providing care for the	e residents. The document			
	identified six of the th	nirteen spaces used to			
	identify staff, to be bla	ank.	4		
	> On the AM shift, 10	0/21/15, the Mill Creek Bridge			
	had no NA displayed,	, only having a nurse			
	assigned to provide c	care to the residents.			
	Northwoods had one				
		residents. The document			
	•	e thirteen spaces used to			
	identify staff, to be bla				
	•				
	> On the AM shift, 10	0/22/15, the Lake View Lane			
		ed, and only one NA. Mill			
		orthwoods again each only			
		ne NA identified as providing			
		nt identified six of the thirteen			
	spaces used to identi				
	opaces asea to lacilli	ny dan, to be blank.			

Minnesota Department of Health STATE FORM

> On the AM shift, 10/23/15, the Oasis unit had

Minnesot	<u>a Department of Healtl</u>	<u>n</u>					
	OF DEFICIENCIES	(X1) PROVIDER/SI				(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION	ON NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
		00714		B. WING		40/0	C/0045
		00714				10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			310 LAKE I	BOULEVARD			
LAKE RID	GE CARE CENTER OF E	BUFFALO	BUFFALO,	MN 55313			
(X4) ID	SUMMARY ST	ATEMENT OF DEFIC	IENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX		Y MUST BE PRECED		PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING IN	FORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
					DEFICIENCY)		
2 800	Continued From page	e 28		2 800			
	no staff name identifie						
	work on the unit, and						
	have a nurse identifie						
	five of the thirteen spa	aces used to ide	entify staff, to				
	be blank.						
	On 10/26/15, at 5:06						
	(DON) stated, "Right						
	staffing. It is the drive						
	stated, "We work with						
	resources] all the time						
	staff." The DON adde						
	everything else that w	-					
	quality deficiencies] a						
	concerns] There are						
	not be an issue if we	• .	•				
	floor." The DON state	•	-				
	was well aware of the	•	•				
	and the quality conce	•					
	insufficient staffing. D		•				
	staffing shortage beg						
	summer when studen		•				
	there were also eight						
	maternity leave as we						
	facility was still accep						
	stated they had delay						
	later in the week whe						
	discharged. When as		•				
	identified or addresse						
	were not receiving ba						
	stated, "This is one of						
	staffing we were do						
	second week of Septe						
	to have a bath aide [b						
	September I think e	verybody is get	ung really				
	good wash ups."						
	During interview on 1	0/26/15 at 4:24	n m				
	During interview on 1 administrator stated t		•				
	determined based on						
	acterrimen based off	uic size oi tile i	ounding, and	I		ļ	

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 29 of 105

Minnesota Department of Health

_	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DA		URVEY ETED
		00714	B. WING		10/2	6/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 800	if they, "Have a lot of needs." The facility of down in census, and number of hours divic residents) to determine resident, so being down amount of dollars." Thad, "Certainly identification in the focus staff adding it had been time." A facility policy on stanone was provided. SUGGESTED METH The director of nursin and/or revise facility prelated to sufficient stand procedures. State evaluated for insufficient residents, employees could be identified and the insufficiencies ided documentation maintacould be developed a results shared with the Assessment & Assura on-going compliance.	residents that have more oes cut hours if they are uses a formula (total led by the number of he the number of hours per wn one bed equals, "X he administrator stated he he died there is a problem" with s was to hire and recruit new en the focus, "For a long ffing was requested, but OD OF CORRECTION: g or designee, could review policies and procedures affing. Responsible he-educated on these policies ffing patterns could be hency, with input from hand families. Interventions d implemented to remedy ntified, with supporting hand implemented, with he facility's Quality hance committee, to ensure	2 800			
2 830	MN Rule 4658.0520 S Proper Nursing Care;		2 830			12/29/15
	-	eneral. A resident must and treatment, personal and				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 30 of 105

Minnesota Department of Health

	a Department of Healtr		1			
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
VIAD LEWIN (O CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		L1LD
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		310 LAKE	BOULEVARD			
LAKE RID	GE CARE CENTER OF B	BUFFALO	, MN 55313			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N .	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
			+			
2 830	Continued From page	e 30	2 830			
	custodial care, and su	pervision based on				
		preferences as identified in				
		esident assessment and				
		ribed in parts 4658.0400 and				
		g home resident must be out				
		essible unless there is a				
		attending physician that the				
	prefers to remain in b	in bed or the resident				
	prefers to remain in b	eu.				
	-	t is not met as evidenced				
	by:					
		n, interview and document		Corrected.		
		ed to comprehensively nterventions to reduce pain				
		R118) reviewed for pain.				
		nts of unmanaged pain, and				
	•	sing pain during a wound				
	dressing change. The					
		chair positioning for 1 of 1	4			
	i i	was leaning significantly to				
	the right side.					
	Findings include:					
	Findings include:					
	PAIN					
	R118's undated Resid	dent Admission Record				
		ncluding peripheral vascular				
	_	arthritis in right hip, cellulitis				
		emity, non-pressure chronic				
	ulcer of lower right leg	•				
		n syndrome, and Trigeminal				
	Neuralgia (nerve pain	1).				
	The admississ Mississ	um Data Cat (MDC) datad				
		um Data Set (MDS) dated 18's cognition was intact				

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 31 of 105

Minnesot	ta Department of Health	1				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		GOINII EETEB	
		00744	B WING	B. WING		
		00714	B. WIIVO		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 830	Continued From page	31	2 830			
	and she required limit activities of daily living identified R118 did not medication, but receive medication and non-printerventions for pain identified the pain manight, and limed her coursent pain was to 10, numeric pain rate the most intense parawas identified as frequerbal description of the MDS identified she have ulcer at the time of the the time of the transport of the t	ted assistance for most g (ADLs). The MDS of receive scheduled pain ared as needed (PRN) pain charmacological management. The MDS de it difficult to sleep at lay to day activity. A all pain rating scale identified a nine out of 10 (a zero (0) ating scale of 0 = no pain, 10 atin imaginable). Her pain usent, but did not include a the pain even though the ad one arterial or venous at MDS. sment (CAA) dated 8/24/15, and assistance with all ADLs decreased mobility from the CAA identified R118 had right leg that was infected in large amounts of fluid. The "Is complaining of pain due arthritis, and stasis ulcer on a that PRN Tramadol medication] relieves pain. Is and repositioning. Staff or for pain and update MD reded." The to sleep, and limited her are facility had not assessed as if the pain regime was				

Minnesota Department of Health

osteoarthritis and stasis ulcer to her right lower

STATE FORM 6899 28WI11 If continuation sheet 32 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
LAKE RIE	GE CARE CENTER OF B	BUFFALO	BOULEVARD		
	CLIMMA DV CT		, MN 55313	DROWDEDIC DI AN OF CORDECTIO	N
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 830	extremity. The care postate her pain was de analgesic, or show no pain. Interventions indoes a calculate a sable of the care and the calculate and the calcu	lan goal was for R118 to creased with the use of an on-verbal signs of decreased cluded the following: eport pain levels PRN, per a export pain levels PRN, and pain. In an	2 830		

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 33 of 105

PRINTED: 12/06/2016

Minnesot	a Department of Health	1			FORM	APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		00714	B. WING		10/2	26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		310 LAKE	BOULEVARD			
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	2 33	2 830			
	dressing change was LPN-F to return in a hardressing change and 10:01 a.m., R118 stat never quite cuts it withere's nothing [that of 10:11 a.m., LPN-F gadressing change. Who room, R118 was asked medications were held does," and rated her pain scale. At 10:16 at R118's resident room preparations for the dabout to begin the tree "Where's my ice pack forgotten to bring the immediately upon corchange. R118 said loth that now." LPN-F said retrieved an ice pack dressing change. At 10 the Kerlix (gauze ban highly absorbent drespadding and protections."	ping. She stated, "[It] never pain a seven, out of 0-10 n.m. LPN-F returned to completed her ressing change and was atment when R118 asked, "?" LPN-F stated she had ice pack, but would bring it mpletion of the dressing udly and firmly, "No. You get d, "Okay, yes mam." LPN-F and then began the 10:22 a.m., LPN-F removed dage rolls) and ABD pad (a				

Minnesota Department of Health

pieces of Silversorb (an absorptive dressing) and slough, by wiping, rolling and picking off the black colored debris from R118's open wound. While

completing debridment of the wound R118 was wincing, jerking and pulling away throughout the procedure. At 10:27 a.m., R118 had tears in her eyes, which she wiped with tissue paper that she held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing

LPN-F was removing the dressing and

Minnesot	a Department of Health	1			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE	
310 LAKE BOULEVARD					
LAKE RID	GE CARE CENTER OF E	BUFFALO	D, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 830	Continued From page	2 34	2 830		
	her face, and choked voice, and said "okay stated, "Okay, it's stated, it's she had not le medication to begin with lower leg and mastockinet and gripper allowing R118 to bread dressing change was that time to administe medication (oxycodor pain medication) to R the medication, applied gripper stocks, and at R118 rated her pain addressing change, stated because I'm about repain." At 10:43 a.m., pack, firmly to her leg her pain as an eight (was starting to decline ask R118 to rate her pain as an eight (was starting to decline ask R118 to rate her pain as an eight of the dressing change of administered PRN particularly	athe, and rest after the completed. LPN-F used or another PRN pain the 5mg 1 tablet, narcotic 118. LPN-F administered at R118's stockinet and at 10:37 a.m., left the room. It is a nine, and during the ated, "It's gotta hit 15, addy to pass out from the R118 was still holding the ice . At 10:45 a.m., R118 rated 8) and stated her pain level at this time. LPN-F did not to ain before, during or after			

Minnesota Department of Health

pain management regimen for R118 for some

STATE FORM 8899 28WI11 If continuation sheet 35 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING: COM			
			A. BUILDING:			
		00714	B. WING		10/26/2	015
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	KE BOULEVARD			
			LO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETE DATE
2 830	Continued From page	e 35	2 830			
2 830	time. She was not suphysician was, for not the pain medicaiton rotrys to give her (R118 the dressing, so she (and "get her bearings when she is ready. R118's current physic directed the following management regimer. Wound treatment to lower extremity- clear cover with ABD pad adaily and PRN. Gabapentin 300 milliperipheral neuropathy. Ultram 50 mg, every chronic pain syndrom. Oxycodone 5 mg, even not relieved by Ultram Review of R118's phy 8/17/15, to 10/26/15, R118's New Patient Hexamination, complet (MD)-A and dated 9/3 osteoarthritis affecting hip, with residual pair arthroplasties. The reher pain. On 8/24/15, nurse prahad complaints of pair	are what the rational of the thaking further changes to begimen. LPN-F stated, She by time when she removed (R118) can take a breath sill and will then continue stand orders dated 10/26/15, wound treatment and pain in: stasis ulceration on right inse wound, apply Silversorb, and Kerlix, change dressing sigrams (mg), twice daily for many polyneuropathy. Four hours PRN for pain, for the every four hours PRN for pain in, for chronic pain syndrome. Assician progress notes from identified the following: distory and Physical ted by medical doctor syndromes are knees, shoulder and in post knee and hip port did not further address actitioner (NP)-A noted R118 in to her right lower extremity	2 830			
	R118's right lower leg treatments. NP-A note will add oxycodone for pain."	ted the appearance of and reviewed the dressing ed, "Discussed pain control or mod [moderate]/severe				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 36 of 105

Minnesot	<u>a Department of Health</u>	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00714	B. WING		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE. ZIP CODE		
			E BOULEVARD	,		
LAKE RID	GE CARE CENTER OF E	BUFFALO	O, MN 55313			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	NATE DATE	
0.000	.		2 222			
2 830	Continued From page	e 36	2 830			
	History and Physical	noted, "There is a wound on				
		ion of [R118's] right lower				
	leg. This measures 1					
		ound is about 60% yellow				
		ed. It is very tender to touch any sort of debridment on				
		to be infected I initially				
		ent's wound with Medihoney;				
		developed a lot of discomfort				
	with this. My initial inc	clination had been to treat it				
		tempt to control drainage				
		raid that that would be				
	•	eive a dose of oxycodone				
	then dressed"	in got better her wound was				
		dressed R118's chronic right				
		noted, "Resident today				
	•	vning and awaiting R [right]				
		lressing [change]. C/o				
		R LE. Refuses to go back				
		Clinic- 'They don't know				
		particular about what she will				
		E wound looks unhappy- change]." The note directed				
	no change to the wou					
	-	ic treatment for cellulitis				
	through 10/12/15.					
	On 10/19/15, NP-A no	oted R118's emergency				
	room visit was review					
	address R118's stasis					
		nt, description, or plan for				
	pain management we progress notes.	ere included in the physician				
	progress notes.					
	Review of R118's Ele	ctronic Medication				
		d (EMAR) from 9/1/15, to				
		e following as PRN pain				
		ministered for right, lower				
	extremity and leg pair	٦.				

Minnesota Department of Health STATE FORM

28WI11 If continuation sheet 37 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LAKE RID	LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BUFFALO				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 830	Continued From page	: 37	2 830		
	The September 2015 a total of 103 doses of She took 68 doses of effective 42 of 68 opp 14 of 68; not effective was not identified for R118 had 35 doses of September 2015, whi 35 opportunities; slight other which was not identified for September 2015. Whi 35 opportunities. The October 2015 EN administered 100 dos right, lower extremity doses of Ultram 50mg of 49 opportunities; slightly doses of Ultram 50mg of 49 opportunities; slightly effective 5 out of 51 a identified, 1 out of 51 Review of the EMAR from September to Octorrelate with R118's the dressing changes documented. Even though R118 was of PRN pain medicating approximately 3.7 dose each day, along with 300 mg twice a day. Finally services and the services of the se	EMAR identified R118 took f PRN pain medication. Ultram 50mg, which were ortunities; slightly effective 2 of 68, and other, which 1 of 68 opportunities. If PRN oxycodone 5mg in ch was effective 14 out of offitly effective 3 out of 35; and dentified 3 out of 35, MAR identified R118 was es of pain medication for leg pain. She took 49 g, which was effective 18 out ightly effective 17 out of 49; t of 49 opportunities. If PRN oxycodone 5mg, in was effective 34 out of 51 effective 11 out of 51; not not other, which was not opportunities. PRN administration times ctober 2015, did not dressing changes, because were not consistently as administered 203 doses on, taken in 55 days, ses of PRN pain medication her scheduled Gabapentin			

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 38 of 105

Minnesot	<u>a Department of Health</u>	า				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00714	B. WING		10/26/2015	
NAME OF D	ROVIDER OR SUPPLIER	QTDEET AF	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	TOVIDEIT OIT 301 1 EIEIT		BOULEVARD	KIE, ZII GODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO), MN 55313			
	OLUMBA DV OT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
2 830	Continued From page	e 38	2 830			
	Davious of D110's pur	aing progress notes from				
		sing progress notes from 6/15, identified complaints				
	of pain for R118:	.o/ 15, Identified Complaints				
	On 8/24/15, at 10:18	n m I PN-G noted				
		n lower right leg About an				
		ad c/o a 'burning pain.'				
	Writer asked if a pain	pill would help or if it was				
	too much and it need	ed to be taken off? Resident				
	asked for it to be take					
	~	ound and only applied				
		tick dressing then covered				
		ed with Kerlix. Resident has	4			
		c/o pain but is requesting				
	that won't burn."	ething else on the wound				
		.m. LPN-D noted, "[R118]				
		resident alginate dressing				
		e on skin;communication				
		PMD [primary medical				
	doctor]."	-				
		a.m. LPN-F noted, "Leg				
		Area continues to be red,				
		nder to the touch Resident	1			
		ay hurts her when use for				
	-	dent refused it to be used				
	on her D/T [due to] re	.m. LPN-D noted, "[R118]				
	· ·	ssing removed per [R118's]				
	•	plied with some relief; leg				
		ill reassess in one hour				
	when may have prn p					
	, , ,	n. registered nurse (RN)-C				
		d to have dressing put on in				
		t hurting again [R118] is				
	leaving it open to air.	-				
		LPN-B noted, "Writer called				
		d left a message regarding				
		ner leg. Resident is refusing				
	to let staff place a dre	essing on her leg per				

Minnesota Department of Health

orders."

STATE FORM 6899 28WI11 If continuation sheet 39 of 105

Minnesot	a Department of Health	1				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
			7 20.125101.			
		00714	B. WING		10/26	6/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
I AVE DID	OF CARE CENTER OF R	310 LAKE	BOULEVARD			
LAKE KID	GE CARE CENTER OF B	BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	÷ 39	2 830			
	On 9/8/15, 11:10 p.m. pain to RLE. [R118] is prn pain medication for call physician said to Tylenol. Will administ monitor." On 9/13/15, at 12:25 [R118] does c/o pain of change PRN pain mat this time." On 9/19/15, at 1:12 a c/o 7/10 pain right low relieved with prn Trand dressing changed by On 9/23/15, 10:39 p.r medicated as directed 'It burns so bad when On 10/8/15, at 2:09 p.continues to c/o pain changes et PRN pain when 2 different PRN closer together. Resident makes requived with some change when NP was On 10/12/15, 2:27 p.r. continues to c/o pain. Resident makes requived Leg continues to be promised prior to tall treatment is being commed prior to tall treatment it is open On 10/17/15, at 11:37	LPN-C noted, "[R118] c/o is unable to have any more or another 2 [two] hours. On o use standing order of er Tylenol and continue to p.m. LPN-B noted, " during a.m. dressing nedication given x [times] 2				

Minnesota Department of Health STATE FORM

During interview on 10/26/15, at 10:42 a.m.

6899 28WI11 If continuation sheet 40 of 105

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		- GONOTINO	COMPLETED	
			7. BOILDING.			
		00744	B WING	B. WING		0/0045
		00714	J		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
I AKE RID	GE CARE CENTER OF B	310 LAKE	BOULEVARD			
LAKE KID	OL OAKE OLNTER OF E	BUFFALO,	MN 55313			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAO		,	IAG	DEFICIENCY)		
2 830	Continued From page	. 40	2 830			
2 030			2 000			
)-A stated, R118 has pain in				
	_	seen her "pretty upset and				
	, , ,	nas seen R118 in pain				
		d of pain to her almost daily.				
		the facility nurses when				
		and/or appeared in pain, to				
	NA-A stated the pain	ven any pain medication.				
	"somewhat effective,					
	[effective]."	[but] never 100%				
	[Circolive].					
	During interview on 1	0/26/15, at 2:32 p.m.				
	_	-H reported R118's pain				
	, ,	nt lower leg, where she had				
		stated the area has been				
	improving, but was ta	king a long time. Upon				
		RN-H reported R118's pain				
		ound an 8 (0-10 pain scale)				
		PRN pain medications. She				
		ician was at the facility every				
	_	sponsible for monitoring to				
		agement regimen was				
	•	RN-H stated the most recent	1			
		ian/ nurse practitioner ain was the physician's				
		0/8/15. RN-H reported R118				
		d clinic, but stopped going				
		e she was very upset and				
		re anymore. RN-H stated				
		I18 about her pain, as				
	T =	and she had indicated				
	_	ain management regimen.				
		18's acceptable level of				
		e was unsure. RN-H stated				
		118 had significant pain with				
		t believed the current pain				
		was effective for her. She				
		118's wound was going to				
		able pain during dressing				
	changes. However, w	hen told of the observed				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 41 of 105

Minnesot	<u>a Department of Healtl</u>	h						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMB	ER:	A. BUILDING: _		COMPLE	ETED	
		00714		B. WING		10/2	6/2015	
		00111				10/2	0/2010	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
I VKE DID	GE CARE CENTER OF E	RIJEENIO	310 LAKE B	OULEVARD				
LAKE KID	OL CANL CLIVILIC OF L	DOLLACO	BUFFALO,	VIN 55313				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PREFIX		Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE	
TAG	REGULATORT OR I	LSC IDENTIFTING INFORMATION	JIN)	TAG	DEFICIENCY)	.IAIE	DAIL	
2 830	Continued From page	e 41		2 830				
	dressing change on 1	10/22/15, RN-H denied						
	•	aving reactions to that						
	_	d, "If she [R118] is sayir	ıa l					
		ich pain, she is having t						
		nied any reports of pair						
	-	om the facility nurses or						
		ne expected staff would						
		sician if/when they ider						
		the physician could hav						
		ncrease in R118's pain						
	medication. RN-H sta	ated R118's use of the id	e					
	pack was typical, how	vever, "If that was what	we					
	were seeing, then that	at would not be a sufficie	ent					
	management of her p	ain." RN-H confirmed,						
	R118's pain should ha	ave been reassessed. F	RN-H					
	confirmed the facility	used section J of the M	DS					
		essment, which was on	ly					
	completed on a quart	erly basis.	4					
			Ĭ					
	•	0/26/15, at 5:11 p.m. th	e					
	director of nursing (D							
	completed R118's dre	•						
	frequent basis. She n							
		hour before the dressir	ng					
	change and asked he	. ,						
		ing change, how she wa						
	•	ed she soaked the Silve						
	•	nt of normal saline to ke						
	_	eg and made sure she h	ad					
	T	r her leg at the time of						
		e DON stated she typica	ally					
		ried to get her to laugh,						
	•	the dressing change. T						
		hese interventions were						
		be." The DON stated, v	/iicii					
	R118 was first admitte		,an					
		re much more painful the						
		The DON stated she ha						
		during a dressing chang of the observed dressing						
	and upon discussion	or the observed dressin	9					

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 42 of 105

Minnesota Department of Health

AND PLAN OF CORRECTION			(X3) DATE SURVEY COMPLETED		
	IDENTIFICATION NUMBER:	A. BUILDING: _			
	00714	B. WING		10/26/2015	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKE RIDGE CARE CENTER OF BUF	FALO 310 LAKE E	BOULEVARD			
	BUFFALO,	MN 55313			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
as identified in the 10/22 expected the nurses to comedical record and see a getting some different arker. Although R118, had a staprogress notes that iden had nurses and nursing R118 in pain, either during or other times during the Gabapentin 300 mg twice scheduled pain medicati PRN for pain and oxycoomoderate to severe pain Gabapentin 300 mg priod in the morning of 10/22/2 oxycodone 5mg after the completed. Even though of unmanaged pain, and distressing pain during a The facility did not complete developed an appropriate interventions to assist in The facility's Dressing Cidated 6/14, directed nursorders to see if a resider prior to completion of dressing times and the second	ne denied having seen om R118 any time she wed her dressing ed she expected some of dressing change, but ed significant signs of pain 2/15 observation, she document this in the what they could do about nalgesic medications for dressing changes ed day. R118 only received the aday. R118 only received the area day, for a routine for an Ultram 50 mg done 5 mg PRN for an R118 only received the forto her dressing change and the price of the dressing change are dressing change are dressing change and the price of	2 830			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 43 of 105

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			, 50.25e		
		00714	B. WING		10/26/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUFFALO					
			, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 830	Continued From page	e 43	2 830		
	additional policies we	re provided.			
	R57 used a wheelchaextensive assistance (ADLs). R57's care at 4/21/15, indicated she limited range of motio 9/23/15, indicated alterincreasing weakness physical and occupate A Resident Progress indicated "pillow giver due to resident leaning the same as a single progress and th	dated 9/22/15, identified air for mobility, and required with activities of daily living rea assessment dated a had contractures, and an. R57's care plan dated erations in mobility related to and directed staff to refer to ional therapy as needed.			
	up in wheel chair and right." During and observation R57 was sitting in a way and the state of	would "drift off, leaning to on on 10/19/15, at 8:16 p.m., /heel chair. She appeared to	Q		
	arm, leaning to her rig a.m., R57 was again chair, leaning to her r 8:58 a.m., R57 was le wheel chair with her h table. On 10/23/15, a observed sitting in he	r wheel chair, leaning to her			
	was placed on the rig chair. Although R57 of there were no suppor support her trunk that During and interview	ad resting on a pillow that ht arm rest of her wheel continued to lean to the right, its noted in her wheelchair to prevented her from leaning. on 10/23/15, at 11:32 a.m.,			
	NA-B stated R57 refu	ses to lay down a lot of the			

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 44 of 105

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
I AKE RID	GE CARE CENTER OF E	310 LAKE	BOULEVARD		
		BUFFALC	D, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 830	Continued From page	e 44	2 830		
		ut pillow by her head. NA-B as always leaned to the right at is."			
	occupational therapy R57 was recently give her wheel chair. OTA referral "about a mon picked up for ongoing	n 10/23/15, at 11:48 a.m., assistant (OTA)-J stated en a right lateral support for -J stated R57 was seen for a th or so ago," but was not g therapy. He felt R57's chair but that (R57) was more			
	NA-T stated, R57 is li get her up for breakf in her wheel chair. NA	n 10/26/15, at 1:53 p.m., ike that "all the time," they ast and then she falls asleep A-T further stated, she used leaning has been going on its.	~		
	LPN-H stated, some getting her (R57) to la will place a pillow und uncomfortable position that." LPN-H further sher second chair, and lateral supports or if that high risk for falling she is always leaning stated, R57 had been	n 10/26/15, at 2:07 p.m., they they have difficulty ay down. Sometimes they der her head to buffer the on but, "she always looks like stated, she though this was d was unsure if (R57) had hey helped or not. R57 was out of her chair because to her right. LPN-H further a screened by occupational g, but was unsure if she had			
	occupational therapis they had received a r because of her leanir supports. They also	n 10/26/15, at 2:32 p.m., tt (OT)-K and OTA-J stated, eferral in September for R57 ng and gave her a lateral recommended she (R57) lie d the potential for several			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 45 of 105

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:IED
		00714	B. WING		10/20	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
I AVE DID	GE CARE CENTER OF E	310 LAKE	BOULEVARD			
LAKE KID	GE CARE CENTER OF E	BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	the time of the referral lateral support was present amount of assistance and be able to propel OT-K and OTA-J furth leaning that bad where current positioning was have been referred be evaluation. A policy addressing prequested, but was not support to the director of nursing and/or revise facility prelated to pain manage and coordination of concepts and present the proper identified in the deficition of the needs identified documentation maint could be evaluated for management, proper of care with outside sauditing system could implemented, with resuguality Assessment & ensure on-going comments.	f a sore back, and neck. At al in September 2015, the roviding R57 with the she needed to sit up right herself in her wheel chair. her stated, R57 was "never in we saw her" and that her as a change and she should ack to therapy for an positioning for residents was not provided. OD OF CORRECTION: g or designee, could review policies and procedures gement, proper positioning are with outside providers. The individual(s) ency could be re-educated on pocedures. The individual(s) ency could be reassessed ed, with supporting ained. Other residents or appropriate pain positioning and coordination ervice providers. And the developed and sults shared with the facility's & Assurance committee, to	2 830			
2 840	MN Rule 4658.0520 S Proper Nursing Care;	Subp. 2 B Adequate and Clean skin	2 840			12/29/15
	Subp. 2. Criteria for	determining adequate and				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD		
		BUFFALO,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 840	Continued From page	e 46	2 840		
2 840	proper care. The crit adequate and proper B. Clean skin an odors. A bathing plan resident's plan of care condition requires that must be given a compother day and more of incontinent resident mevery two hours, and following each episod [144A.04 Subd. 11. Notwithstanding Minn 4658.0520, an incontic checked according to written in the resident attending physician minterval longer than twiff competent, or a fam appointed conservato agent of a resident whin writing to waive phydetermining this interval documented in the resident in the resident attending physician minterval longer than twiff competent, or a fam appointed conservato agent of a resident whin writing to waive phydetermining this interval commented in the resident which is the perineal care includes the perineal area. Pat to keep the bed dry an comfort. Special atterskin to prevent irritation types of protectors minder the perineal care includes the perineal area.	d freedom from offensive must be part of each e. A resident whose the resident remain in bed oblete bath at least every ften as indicated. An must be checked at least must receive perineal care e of incontinence. Incontinent residents esota Rules, part ment resident must be a specific time interval 's care plan. The resident's must authorize in writing any wo hours unless the resident, mily member or legally or, guardian, or health care no is not competent, agrees visician involvement in wal, and this waiver is sident's care plan. I may must be provided e bed or clothing is soiled. In the washing and drying of district of the resident's must be used and for the resident's not the on. Rubber, plastic, or other must be kept clean, be and not come in direct	2 840		
	clothing must be removed resident areas to prevent	oved immediately from vent odors.			

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD		
			MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 840	Continued From page	e 47	2 840		
	by: Based on observatior review, the facility fail completed for 2 of 5 r assistance with toileti residents (R126) reviews.	t is not met as evidenced n, interview and document ed to ensure bathing was esidents (R45, R19), and ng was provided for 1 of 5 ewed for activities of daily o were dependant on staff		Corrected.	
	had intact cognition, a assistance from staff During interview on 1 stated she does not a bath because of the fruther, R45 stated n consistently makes he like to have her bathin Facility Lakeside Oas 9/14/15 to 10/21/15 wwere constructed by i week, and staff were which day they receivname on the form and completed. R45's na	to complete her bathing. 0/22/15, at 1:46 p.m. R45 slways receive her schedule acility being short staffed. ot receiving her bath er "angry", and she would			
	staff initials identified	next to her name to identify The spaces provided to			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 48 of 105

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD		
	T		, MN 55313		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 840	Continued From page	e 48	2 840		
	NA-C stated R45 enjorthey were sometimes of staff to complete the During interview on 19 stated she was not awher baths as schedule surprise me." Further have been given her land land land land land land land land	0/23/15, at 11:59 a.m. RN-A ware R45 was not receiving ed, but added it "wouldn't r, RN-A stated R45 should baths as scheduled. dated 9/29/15, identified ion, and required assistance it to complete her bathing. 0/22/15, at 2:11 p.m. R19 psed to receive a bath twice without her baths at times not hear enough" staff at the stated she wanted to eduled baths as it was "very" ridge Weekly Bath and Vital 0/21/15, identified R19 was twice a week. The listing lentifying the days of the to identify a resident on red their bath by writing their d initialing next to it when , R19 was not provided her			
	NA-C stated R19 enjo	10/22/15, at 1:36 p.m. bys her baths, but added sed because there were no			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 49 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
I VKE DID	GE CARE CENTER OF B	310 LAKE	BOULEVARD		
LAKE KID	GE CARE CENTER OF E	BUFFALO,	MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 840	Continued From page	e 49	2 840		
	stated her expectation bathing as required for A facility policy on bath none was provided. LACK OF TIMELY PER 126's admission Mirdated 9/25/15, identific cognition, required extoileting and personal of bowel. R126's care plan date had an alteration in hidecreased mobility, bowel. Further, the complete, "Pericare we [morning] and HS [hocare plan did not idenshould be completed with those set times. During interview on 1 stated he was dependent of the was dependent	ching was requested, but ERICARE: Inimum Data Set (MDS) Inimum Da			
		10/26/15, at 10:27 a.m.			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 50 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SI	
			A. BUILDING: _			
	00714		B. WING		10/2	6/2015
NAME OF PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RIDGE CARE CENTER	E BLIEFALO	310 LAKE	BOULEVARD			
LAKE KIDGE CARE CENTER	DE BUFFALO	BUFFALO,	MN 55313			
PREFIX (EACH DEFIC	Y STATEMENT OF DE ENCY MUST BE PREC OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840 Continued From	age 50		2 840			
R126 with toiletin noticed feces soil before. NA-A sta using it as a barri becoming soiled was using it as a barri becoming soiled was using it bowel movement with pericare's. A letter submitted 10/28/15, authore times [R126] wou the newspapers using it arrival. He had the himself on bedpa was done." A letter submitted 10/30/15, authore to use newspaper told him he didn't change linen if it is newspapers under the director of numerical median in the direct	g and pericare's led newspaper or ed she was unawer to prevent the while waiting for some 10/26/15, at 2: RN)-H stated she newspaper af while he waited to be post survey exited by NA-T noted do have his light of the him prior to be bedpan within rander him prior to be bedpan within rander himself event of the him prior to be bedpan within rander himself event of the him." Toileting and perior to be bedpan within rander himself event of the color rander himself event of the was provided to do that a lot soiled. He country him."	n his bed ware R126 was linens from staff assistance. 18 p.m. e was unaware ter having a for assistance dated l, "A couple of on but he put the [NAs] reach and put only when he dated l, "[R126] chose ven though I and we would ntinued to put ricare was RECTION: e, could review procedures lice with esponsible in these policies vision of ADL the ency, with	2 840			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 51 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SUF	
			7 BOILBING.			
		00714	B. WING		10/26/	2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	UFFALO	BOULEVARD MN 55313			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETE DATE
2 840	Continued From page	: 51	2 840			
	provision of ADL serv could be developed a results shared with th Assessment & Assura on-going compliance.	e facility's Quality ance committee, to ensure				
2 860	MN Rule 4658.0520 S Proper Nursing Care;	Subp. 2 F. Adequate and Hands-Feet	2 860		1	2/29/15
	proper care. The crite adequate and proper E. per care and atten	•				
	by: Based on observatior review, the facility fail completed for 2 of 5 r	t is not met as evidenced n, interview and document ed to ensure nail care was esidents (R5, R64), who ce with activities of daily		Corrected.		
	was seated in a reclin	n 10/20/15, at 9:16 a.m. R5 er chair in his room. R5 mails on both hands with a ce underneath several of the as diabetic so "not				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 52 of 105

Minnesota Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00744	B. WING		40/26/2045
NAME OF D		00714		TE 7/D 00DE	10/26/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA E BOULEVARD	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	D, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 860	Continued From page	e 52	2 860		
2 800	everybody can cut the preference would be 10/22/15, at 9:01 a.m dirty fingernails on both When interviewed on nursing assistant (NA refused cares or assicare was to be complibath days. At 2:03 p. nails and stated they clean underneath." Fewere unaware of any long, dirty fingernails. During interview on 1 licensed practical nur long, dirty fingernails cut." Further, LPN-A on nursing staff for his should have been trir bath day. When interviewed on registered nurse (RN assistance to comple should have been cleshould be taken care done."	em", but added his to have shorter nails. On a R5 continued to have long, oth hands. 10/22/15, at 1:53 p.m. A)-T stated R5 seldom stance from staff, and nail leted on residents scheduled am. NA-T observed R5's were too long, and "not very Further, NA-T stated they preference of R5 to have and they should be trimmed. 0/22/15, at 2:33 p.m. see (LPN)-A observed R5's and stated "they need to be stated R5 was dependent and cleaned on his nail care, and his nails med and cleaned on his nail care, and his nails staned and trimmed, "[They] of when they get their bath dated 9/15/15, identified orgitive impairment, and seistance from staff to	2 800		
	was seated in a stand R64 had visibly long	dard wheelchair in his room. fingernails with several nails d substance underneath			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 53 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00714		B. WING		10	/26/2015
NAME OF PROVIDER OR SUP	PLIER		STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RIDGE CARE CEN	TER OF E	BUFFALO		BOULEVARD , MN 55313			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
shorter kept On 10/22/15 wheelchair of have long, d When interv NA-T stated assistance to observed R6 long" and sh During interv observed R6 been cleane When intervi stated R64 h long, dirty fir cleaned and A facility poli requested, b SUGGESTE The director and/or revise related to the personnel co and procedu care services individual(s) supporting d residents co care. An au implemented	R64 st nails add, at 9:04 utside hi irty finger iewed or R64 had to their knails ould be or iew on 10 ad no de gernails trimmed cy on grout none or the provision of nursing express. Apply a could be restant of the provision of	ated he preferred at the preferred and stated the preferred and stated the preferred and the propriate provision are re-assessed for the preferred and the deficiency at the preferred and the propriate provision are re-assessed for the preferred and the deficiency at the preferred at the propriate provision are re-assessed for the deficiency at the preferred at the propriate provision are re-assessed for the deficiency at the preferred	ise a clip." lated in his inued to inds. 3 p.m. lares or staff 3 p.m. NA-T were "very med. p.m. LPN-A should have in day. a.m. RN-A to have have been care was ction: culd review edures lesponsible lese policies in of nail ir the y, with lother opriate nail veloped and the facility's	2 860	DEFICIENCY)		

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF B	BUFFALO	E BOULEVARD		
		BUFFAL	_O, MN 55313	200 V2500 21 AV 05 00 25	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 860	Continued From page	e 54	2 860		
	TIME PERIOD FOR (14) days.	CORRECTION: Fourteen			
2 910	have a continuous promanagement to reduce unnecessary use of comprehensive resident whome must ensure the A. a resident who without an indwelling unless the resident's of that catheterization without an individual of the catheterization without an individual of the resident who receives appropriate the catheterization without an individual of the resident who receives appropriate the catheterization without an individual of the resident who receives appropriate the catheterization without an individual of the resident wi	e. A nursing home must ogram of bowel and bladder be incontinence and the atheters. Based on the ent assessment, a nursing at: o enters a nursing home catheter is not catheterized clinical condition indicates as necessary; and is incontinent of bladder treatment and services to infections and to restore as	2 910		12/29/15
	by: Based on observation review, the facility fail assess and develop in	t is not met as evidenced n, interview and document ed to comprehensively interventions to promote 1 of 3 residents (R64) incontinence.		Corrected.	
	Findings include:				
	9/15/15, identified R6 impairment, required	num Data Set (MDS) dated 4 had moderate cognitive extensive assistance with ways incontinent" of bladder.			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 55 of 105

Minnesota Department of Health

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
7.1.15 1 2 111	o. co2011	15 E 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A. BUILDING: _			
		00714	B. WING		10/2	6/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKE RII	GE CARE CENTER OF B	SUFFALO	BOULEVARD			
		BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 910	Continued From page 55		2 910			
2 910	R64's Nursing Observed ated 9/18/15, identification incontinent" of bladded of when he needs to a The assessment did recomplemented for R64, incontinence. R64's care plan dated an, "Alteration in elimic weakness following he "Aware of the need to the care plan directed request", and, "Monito patterns and reassess request or as needed. During interview on 10 nursing assistant (NA the bathroom when he but has noticed R64 to urine" lately. Further, set toileting schedule. During observation of a.m. R64 was assisted NA-F removed a visib pad from R64, and pla R64, "Had the wrong have had an "extra at on during the night to skin from being incontremoved incontinence R64 was typically incomplete when assisted to the Further, NA-F stated when he needed to us	vations 3.0 Assessment ed R64 to be "always r, and R64 was "not aware use the toilet appropriately." not identify if any or what gram needed to be to decrease R64's I 9/21/15, identified R64 had ination r/t [related to] ospitalization", but R64 was, void/defecate." Further, I staff to, "Toilet per or for changes in elimination is quarterly and prn [per l." I 2/22/15, at 9:43 a.m. I)-T stated he helps R64 to the requests as care planned, to be "more incontinent of INA-T was unaware of any	2910			

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP		
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	UFFALO	BOULEVARD MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 910	voice his need to use time", and should be I two hours. R64 should urine, "More than a cotolleting ability, and the 9/18/15 should have i for R64 to promote co. Although R64's asses "always incontinent" of aware of when he need appropriately." There needed a scheduled to check and change (not toilet) even though R6 and NA-F stated he divoids. A facility policy on uring requested, but none with the director of nursing all residents who are assure they are received treatment/services to status. The director of conduct random audit ensure appropriate calcimplemented; to reduct incontinence.	0/23/15, at 11:34 a.m. 1-A stated R64 was able to the restroom, "Most of the nelped with toileting every ld not be incontinence of ouple times a day," with his re assessment completed on dentified a toileting program ontinence. Issment identified him as of bladder, and R64 was "not eds to use the toilet was no indication if R64 oileting program, or was a coattempts to place on the late of the late	2 910			
21330	MN Rule 4658.0725 S Routine & Emergency		21330			12/29/15

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	E BOULEVARD O, MN 55313		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	ON
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
21330	Continued From page	e 57	21330		
	must be referred for a unless the resident had examination within the admission. B. After the initial nursing home must a resident wants to see any necessary help to at least an annual basannual dental checkuone year from the da examination or within	s after admission, a resident an initial dental examination as received a dental e six months before al dental examination, a			
	by: Based on observatior review, the facility fail recommendations we manner for 1 for 3 res	n, interview, and document led to ensure dental ere acted upon in a timely sidents (R85) reviewed for the needed new dentures.		Corrected.	
	Findings include:				
	R85's quarterly Minim 9/1/15, identified R85	num Data Set (MDS) dated had intact cognition.			
	R85 was seated in his had visible missing te his upper denture mo spoke. R85 stated hi "Worn down", and we	n 10/20/15, at 10:10 a.m. s room in a wheelchair. R85 eeth on his lower palate, and wed in his mouth while he s dentures were getting, ere, "Not effective anymore."			

Minnesota Department of Health

	a Department of Health		1		Taras = .== a.		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SI COMPLE		
			A. BUILDING:				
			D WING				
		00714	B. WING		10/2	6/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
LAKE DID	OF CARE CENTER OF F	310 LAKE	BOULEVARD				
LAKE KID	GE CARE CENTER OF E	BUFFALO), MN 55313				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE	
IAO		,	17.0	DEFICIENCY)			
21330	Continued From page	. E0	21330				
21000			21330				
		fitting dentures, and would					
	like to have them look	ked at by a dentist.					
	D95's Dationt Progress	ss Notes dated 8/11/15,					
		en seen by the dentist who					
	visits the facility. The	-					
	1	er and lower partial. Lower					
		anchored on any teeth as all					
		are fractured off at the					
		pper and lower partial have					
	extreme occlusial wear, and pt it using adhesive						
		Pt is interested in new	4				
		entist identified a treatment					
		plan full upper and full pt decides to proceed, we					
		urgeon for the extractions of					
	remaining lower teeth						
	Tomaining lower took	. [10010].					
	R85's facility progress	s notes dated 8/11/15,					
	identified R85, "was	s seen by In House Dental		\ \ \			
		ident has all remaining					
		with an oral surgeon & [and]					
		upper and lower denture	1				
		hese recommendations with					
		ooses will send him out to a No further notes were					
		edical record as having the					
	follow up completed f						
	requested by R85 and						
		0/26/15, at 10:05 a.m.					
)-A stated she wasn't aware					
		endation for R85 to have a					
		ated the facility social					
	and concerns with R8	ollowed up on the consult					
	and concerns with Ro	JO.					
	During interview on 1	0/26/15, at 10:22 a.m.					
	_	r (LSW)-A stated she was					
		requesting new dentures					

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 59 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	1
			A. BUILDING:			
		00714	B. WING		10/26/201	15
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD , MN 55313			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	J /	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	(X5) MPLETE DATE
21330	Continued From page since "he came" (adm	e 59 nitted to the facility), but	21330			
	LSW-A stated she wa					
		the dentist on 8/11/15, for				
		oral surgeon. LSW-A				
		completed would have been ogress notes, and she was				
		documentation it had been				
	addressed.					
	Duning a fallow up int	amilians an 40/20/45 at 44-24				
	-	erview on 10/26/15, at 11:21 ne had just spoken to R85				
		oursue getting new dentures				
		ed she would assist the				
	resident to make a de	ental appointment.				
	A facility policy on de	ntal consultation was				
	requested, but none					
	SUGGESTED METH	OD OF CORRECTION:				
		g or designee, could review				
	related to dental servi	policies and procedures				
		e-educated on these policies				
	and procedures. App	propriate provision of dental				
	services could be re-a					
		I in the deficiency, with				
		ation maintained. Other aluated for appropriate				
		rvices. An auditing system				
	•	ind implemented, with				
	results shared with th					
	on-going compliance.	ance committee, to ensure				
	TIME PERIOD FOR 0 days.	CORRECTION: Thirty (30)				
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375		12/29	9/15

Minnesota Department of Health STATE FORM

STATE FORM 6899 28WI11 If continuation sheet 60 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	ATE, ZIP CODE	
I AKE DID	GE CARE CENTER OF E	310 LAF	E BOULEVARD		
LAKE KID	GE CARE CENTER OF E	BUFFAL	O, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21375	Continued From page	e 60	21375		
	home must establish	control program. A nursing and maintain an infection gned to provide a safe and			
	by: Based on observatior review, the facility fail control practices and spread of infection for	t is not met as evidenced n, interview, and document ed to implement infection procedures to prevent the r 1 of 3 residents (R118) bund dressing change.		Corrected.	
	identified diagnoses i		U		
	R118's admission Mir dated 8/24/15, identif	nimum Data Set (MDS) ied R118's cognition was nited assistance for most			
	nurse (LPN)-F was of dressing change to R right lower leg. LPN-supplies, laid a clean beneath R118's right seated in her wheelch between the towel an her hands and applying the soiled stockinet (a	118's open wound to the F gathered the necessary towel directly on the floor foot, while R118 remained nair. No barrier was placed d the floor. After washing ng gloves, LPN-F removed a stretchy fabric used for the soiled dressing with use			

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 61 of 105

Minnesot	a Department of Healtl	h			10111171111101	LD	
STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00714	B. WING		10/26/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
		310 LAKE	BOULEVARD				
LAKE RID	GE CARE CENTER OF E	BUFFALO BUFFALO	D, MN 55313				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO			
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		ΓE	
IAG	NEODE WORLD ON	is a second of the second of t	IAG	DEFICIENCY)	W. (1)		
21375	Cantinuad Francisco	- 64	21375				
213/3	Continued From page	9 6 1	21375				
	absorption pad over t	the open wound to R118's					
		ressing and absorption pad					
		e trash, but the stockinet and					
		de, while LPN-F proceeded					
		Wound Wash to soak and					
	loosen a Silversorb (a						
		s open wound. Dark brown					
		is observed to break free					
		drip onto the towel beneath					
	R118's foot. LPN-F removed the dark brown debris away from the wound using the saline						
		nd removed it. The saline					
		oris/ slough, was dripping	/				
		er leg, onto the towel. The					
		ked through, in a circular					
	_	right heel, approximately six					
	inches in diameter. A	At 10:27 a.m., LPN-F					
		and washed her hands after					
		At 10:29 a.m., LPN-F					
		s and a clean stockinet to					
		ed R118's foot back onto the					
		chair. LPN-F folded the towel					
		over the lined garbage bin.					
		pplies and stepped back the night stand. LPN-F					
		top a Dycem mat, which					
		118's night stand. No barrier					
		the scissors and the Dycem					
		ed to open one of the night					
		s time, R118 self-propelled					
		rd approximately 18 inches,					
		the drawers and put away					
		nt front and back wheels of					
		as observed to roll over the					
	area of the floor that I	became soiled by the					
	soaked towel. Once L						
	accessing the night s						
	self-propelled her wh	eelchair back through the					
		ned to her original position.					

Minnesota Department of Health

At 10:37 a.m., LPN-F retrieved a Clorox

STATE FORM 8899 28WI11 If continuation sheet 62 of 105

Minnesot	a Department of Health	า			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE	
LAKEDID	CE CARE CENTER OF F	310 LAKE	BOULEVARD		
LAKE KID	GE CARE CENTER OF E	BUFFALO	, MN 55313		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	
IAG			IAG	DEFICIENCY)	
21375	Continued From page	. 62	21375		
21070	Continued From page	: 02	21373		
		her medication/treatment			
		oring beneath where the			
	towel was placed, the				
		ner cart and returned to wipe			
		d return it to one of the night did not wipe the Dycem			
		ested the soiled scissors on			
		PN-F stepped away from			
		nal (soiled) stockinet which			
		arlier, was draped over a			
	thin metal bar of R11	8's wheelchair, located			
	_	est, near the right front	1		
		was observed with multiple,			
		prown spots of dried wound			
	drainage.				
	During interview on 1	0/22/15, at 10:51 a.m.			
	_	ner typical practice to use a			
		loor to, "Sop up any fluids			
	that drip to the floor,"	during R118's wound			
		N-F stated she used a			
		pe to clean the surface of			
		ssing change. LPN-F stated	1		
		118 propelled her wheelchair ea of the floor before she			
	-	F stated when she was			
		ies R118 removed the			
	•	led linens she had gathered,			
		ference to rinse out her			
		them, rather than send them			
		When LPN-F was asked			
		ed scissors on top of the			
	•	s night stand, she stated, "[I]			
	· · · · · · · · · · · · · · · · · · ·	ere" LPN-F stated she			
		the scissors apart from her o keep it off of the floor, and			
		ught she had wiped the area			
		e scissors with a sanitizing			
	where she had set the wipe.				

Minnesot	a Department of Health	n					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	:K:	A. BUILDING:		COMPLETED	
		00714		B. WING		10/26	/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDE	RESS, CITY, STA	TE ZIP CODE		
IVAIVIL OF T	NOVIDER OR OUT FEEL			BOULEVARD	12, 211 0002		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BUFFALO, I				
	OLIMANA DV. OT	ATEMENT OF DEFICIENCIES	BOITALO,		DDOVIDEDIO DI AN OF CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU	LL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
21375	Continued From page	e 63		21375			
	During interview on 1	0/26/15, at 2:24 p.m.					
)-B, the facility's infectio	n				
		tated disinfectant and					
	sanitizing wipes shou	ild have been amongst t	he				
	supplies LPN-F gathe	ered for R118's dressing					
		without a proper barrier					
	-	PN-F should have disinfo					
	_	ely, and if the wheelcha					
		the soiled area, it should	,				
	stated a barrier shoul	mmediately. RN-B also					
		cissors and R118's nigh					
		stockinet should have b					
	-	nd replaced with a clean					
		aterial was obviously soi					
	needed to go to the la	aundry for cleaning.					
	_	Control Committee- Du					
		policy dated 6/14, direct se was responsible for	ea				
	developing training pr						
	personnel on infection						
		mittee was also respon	sible				
		ty maintained a sanitary					
	environment, with all						
		control procedures and					
	· ·	lity's training program w					
		tective barrier equipme					
		tamination and disposal					
	equipment when expo	osed to blood/ bodily flu	ias.				
	SUGGESTED METH	OD OF CORRECTION:					
		g or designee, could re					
		policies and procedures					
	related to infection co						
		esponsible personnel co	ould				
		ese policies and proced					
	, ,	ould be developed and					
		sults shared with the fac					
	Quality Assessment 8	& Assurance committee	to				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 64 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21375	Continued From page	e 64	21375		
	ensure on-going com	pliance.			
	TIME PERIOD FOR (one (21) days.	CORRECTION: Twenty-			
21426	Prevention And Control (a) A nursing home production and comprehens infection control programment tuberculosis in issued by the United State Control and Prevention Tuberculosis Eliminat Morbidity and Mortalit This program must indiffection control plant unpaid employees, corresidents, and volunted Health shall provide the regarding implemental	provider must establish and ensive tuberculosis fram according to the most effection control guidelines. States Centers for Disease on (CDC), Division of ion, as published in CDC's ty Weekly Report (MMWR). Clude a tuberculosis that covers all paid and contractors, students, eyers. The Department of eechnical assistance ation of the guidelines.	21426		12/29/15
	by: Based on interview ar facility failed to ensure two-step tuberculin sk employees whose per	ne potential to affect all 42		Corrected.	

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	=1ED
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21426	Continued From page	e 65	21426			
	Findings include: Review of personnel of employees, identified was hired on 7/23/15. Was administered on negative with no industep was not complete. Maintenance-A was han initial TST had been and read as negative 8/28/15, no second stomation in the person of the second stomation of the person of the second stomation of the person of t	files for a sample of new nursing assistant (NA)-B. Although an initial TST 7/23/15, and read as ration on 7/25/15, a second ed. sired on 8/26/15. Although en administered on 8/26/15, with no induration on the had been completed. 15. Although an initial TST ed on 9/10/15 and read as ration on 9/13/15, no second eted on entrance of the example of t				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 66 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE	
I AKF RID	GE CARE CENTER OF E	310 LAKI	E BOULEVARD		
LAKE KID	OE OAKE GENTER OF E	BUFFALO	O, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21426	Continued From page	e 66	21426		
	7/13, directed testing with Mycobacterium teither a two-step TST release assay (IGRA) SUGGESTED METH The director of nursin develop and implemented to the required process. The quality committee could perfensure compliance. TIME PERIOD FOR (21) days.	for the presence of infection uberculosis by administering for single interferon gamma in the control of the co			
21475	Subpart 1. General rehome must have an ordepartment or progra related social service nursing home must modilaborate with outsit who is in need of add substance abuse, or the substance abuse, or the substance abuse or the substanc	equirements. A nursing organized social services on to provide medically so to each resident. A make referrals to or de resources for a resident itional mental health, financial services. It is not met as evidenced on, interview, and document ed to ensure medically so needs were identified and sidents (R29 and R28) ervices. This resulted in narm for R28, who ity to sleep, and	21475	Corrected.	12/29/15

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 67 of 105

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00714	B. WING		10/26/20	15
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD			
			, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CO	(X5) MPLETE DATE
21475	Continued From page	e 67	21475			
	concerns with her roo	mmate (R29).				
	Findings include:					
	8/25/15, indicated the cognitive impairment depression. R28's quarterly MDS resident had severe chad dementia with de indicated R28 was de sleeping, had little or herself, and had troub R28's Care Area Asse 6/12/15, indicated the antidepressant, for dia R28's care plan dated	and had dementia with dated 9/1/15, indicated the cognitive impairment, and pression. The MDS pressed, had trouble no energy, felt bad about ole concentrating.				
	encourage expression possible reasons for the environmental/psychological conditions, et management plan to esertraline (Zoloft)." The had the potential for a cognitive loss, and the	n of feelings and to, "Explore the resident's distress (e.g., psocial stressors, treatable tc); Implement a mood compliment drug therapy: the care plan indicated R28 abuse from others related to be approach was for staff to sues with the team members that the need for				
	. •	reviewed from 7/09/15, to e following incidents related roommate:				
		dent] has been crying today. hen she was little her mom				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 68 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G:	· ,	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/	26/2015
NAME OF PROVIDER OR SU	JPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
LAKE RIDGE CARE CE	NTER OF E	BUFFALO	LAKE BOULEVAR FALO, MN 55313	D		
PREFIX (EACI	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
like it. Res asks so mashe is getting the special shape of the special s	ike her war is has also any question ing tired." is, a note do Resident is is a tation. Sh is because g, delusion esident of the inhopes of esident and do about the is, resident is resident and do about the is, a progres Spoke with last night, com today, is to her roce eather. Wrident know about anyther "Resident blocking row when in room in to make resident tag g my mind, at 1 am. T	the the baby and she didn't been say that her roommate ons and needs things and occumented by activities a having a hard time with her ne says she is not getting roommate is up a lot at hal as to where she is and things. Resident is crying a changing rooms. Writer d said she would see what he situation." and roommate had a her roommate yelled at her et, was crying, and stated g with her roommate and see roommate and see roommate yelled at her et, was crying, and stated g with her roommate and see roommate and see roommate and see roommate yelled at her et, was crying, and stated g with her roommate and see roo				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 69 of 105

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	10,20,2010	
I AKE RID	GE CARE CENTER OF E	310 LAKE	BOULEVARD			
LAKE KID	OE OAKE OERTER OF E	BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
21475	Continued From page	e 69	21475			
	worker], 1 on 1 with resident, and was effective at this time." On 9/10/15, resident complaints of not sleeping.					
	On 9/10/15, resident complaints of not sleeping well last night stating the lady in her room kept her up asking who she is and where she is.					
	her up asking who she is and where she is. On 9/10/15, progress note from social services indicated, "Writer was walking down the hall and res stopped writer and was upset because she stated 'I just saw on TV that I am being taken to court! I have nothing, this is not fair they stole all my money!' When writer asked who stole her money she was not able to say. Res roommate was then coming out of the room and res said 'oh that little bitch! She was screwing with him all night!' Writer let res know that was not nice to call some one names. Writer asked who him was and roommate got closer res said 'oh look here she is she just wants to screw' and she shook her fist at roommate. Writer directed ladies in opposite direction but it took some time for residents to go there separate ways. Res kept stating that 'this is my room' and 'she goes in there all the time and screws him, she is such a little bitch, I cant even eat- I don't even want to look at her."					
	and she stated she do	found in roommates bed bes this to me all the time. stated she was up all night				
	•	orn yelling all riight. vas, "Going crazy." One to				
	res was asked what? neck- I don't sleep ca	nplugged cord from 'I wish I had one of those' 'That cord for around my use of that lady in my room.' ont do that but I never get				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 70 of 105

	a Department of Health		1		Tara	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE S COMPLE	
			A. BUILDING:			
			D WING			
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
I AVE DID	GE CARE CENTER OF E	310 LAKE	BOULEVARD			
LAKE KIL	GE CARE CENTER OF E	BUFFALO	, MN 55313			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
				DEFICIENCY)		
21475	Continued From page	= 70	21475			
	relief. SS updated."	there.' 1 on 1 was given with				
	Tollor. Oo apaatoa.					
	On 10/6/15, social se					
		alled, "To talk to writer about				
		nt called her about a man d her roommate, who was				
		s of men and how resident				
		t suicide. Assured Dtr				
		en were in the building and				
		out seeing the men before				
	-	e not here and roommate				
		her bed at night to which figured and was not worried				
		er] was most worried about				
		[Daughter] is requesting a				
	_	dical doctor] when he is here				
	_	ter let [daughter] know that				
		as well about res behaviors. res about suicidal behaviors				
	•	to harm herself and is safe				
		action needs to take place				
	today."					
	On 10/07/15 "Dec in					
	·	confrontation with another ening. Res was talking				
	,	ny lawyer this week to see				
		oing to be.' She was also				
	talking about how and	other res 'needs her ass				
		lly calmed down and went				
	into her room. Will co	ontinue to monitor."				
	A Lake Ridge Care C	enter Fax Update/Order				
		ndicated the MD attempted				
		r but had the wrong phone				
		d call the social worker				
	tomorrow.					
	On 10/20/15 "Milton	informed by NAD (nursing				
		informed by NAR (nursing that Res claims roommate				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 71 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/26/2015
	ROVIDER OR SUPPLIER	310 LAKE	DRESS, CITY, STA BOULEVARD , MN 55313	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21475	daughter to inform da asked aides what hap roommate didn't want had said she didn't want had the claim that roomm. Aides said roommate make such a commet separated at this time bed." On 10/22/15, social s with resident and disc on 10/20/15. Res staroommate was going she felt safe and was She stated her roomr room that's all and sh sometimes. Asked reher roommate during times res waved her lyes its fine." On 10/23/15, social s resident came to write because of all of her to get out of her room gets mad at her and see Because she was so like hurting herself and think so." On 10/23/15, "Reside saying I am getting or resident, Oh it's raining out there. Resident main. I'm not staying I these awful people he was resistant at first to get out of first the saying I am getting or resident, Oh it's raining out there. Resident main. I'm not staying I these awful people he was resistant at first to get out of first and the saying I am getting or resident, Oh it's raining out there. Resident main. I'm not staying I these awful people he was resistant at first to get out of first to get out of first and the saying I am getting or resident, Oh it's raining out there. Resident main I'm not staying I these awful people he was resistant at first to get out of first to get out of first and the saying I am getting or resident first to get out of first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident first and the saying I am getting or resident firs	o cut her throat. Res called hughter of situation. Writer opened. Aides said to go in room because Respect there. Then Res made attended she'd cut her throat. Wasn't even around Res to her. Res and roommate her Res on her way back to her	21475		

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 72 of 105

Minnesota Department of Health

STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00714	B. WING		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
I AVE DID	GE CARE CENTER OF E	310 LAKE	BOULEVARD			
LAKE KID	IGE CARE CENTER OF E	BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21475	Continued From page	e 72	21475			
	social services and n put a Wanderguard o An Associated Clinic	ursing. At this time nursing n resident." of Psychology visit note				
	and did not have suice	ted R28 had depression,				
	recommendations we					
		appeared to have concerns,				
	or when she voiced c	oncerns.				
	dated 9/10/15, indica	Of Minnesota physician visit ted, "The patient [R28] did				
		while complaining about				
		nmate. I spoke with various he patient has had problems				
		of other roommates and I				
	-	ndidate for a private room."				
		facility staff, "I will be happy				
	to support a waiver re	equest for a private room."				
	There was no indicati	on the physician				
		arding R28 receiving a				
		owed up on by the facility.				
	During interview on 4	0/20/45 at 4:52 a				
	During interview on 1	0/26/15, at 1:53 p.m. .)-T stated R28 and R29				
	` `	es being roommates a few				
		R29 gets, "Crazy" in the				
		ght time. R29 becomes				
		s up hollering during the				
		ey have come to work in the				
	of bed crying stating	8 would be awake and out				
	roommate because R					
	uncomfortable." R28					
	_	that room," and continued to				
		naving to remain in the room				
		ongoing episodes several				
	times a week of not s because of R29, and	NA-T stated these concerns				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 73 of 105

Minnesota Department of Health

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		40/26/2045	
					10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD MN 55313			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
21475	Continued From page	e 73	21475			
	were reported to soci stated she had spoke didn't want the reside rather just wanted the pictures and music to space of the room for R28's daughters had town, and she had ex change rooms becauwas," between R28 a stated, "Nothing ever R29 rooming togethe During interview 10/2 stated R28 and R29, [R29] is very forgetful minutes to the next." room she is on and the things and it upsets be upset and will go on a her family; she has sa never told me she has suicide checks. We a	al worker (SW)-A, but SW-A n to R28's family and they nt to change rooms, but a facility to add some try to enhance the physical R28. NA-T stated one of recently visited from out of pressed desire for R28 to se she could, "See how it nd R29; however, NA-T got done," about R28 and r. 6/15, at 4:08 p.m. NA-A "Argue all the time, and ; she cant remember five She forgets what side of the ney both dig into each others oth of them. "[R28] gets a rant that she has no one in aid she is better off dead but d a plan. She is not on any are told there is not enough hem and the nurses do the				
	practical nurse (LPN) R29] fight a lot. I have and left messages wi almost ready to give a nothing gets done wit frustrated, they don't and about what would be compatible with wi [R28] to move to roor	6/15, at 4:13 p.m. licensed -A stated, "They [R28 and e asked for a room change th the social worker. I'm up; we keep charting and h it and the staff are very ask us about room changes d work best, and who would no. I suggested for her n 126 when that was open I the other roommate would				
	,	never moved her. [R28] move [R28] says things				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 74 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		00714	B. WING		10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		310 LAKE	BOULEVARD			
LAKE RID	GE CARE CENTER OF B	BUFFALO	MN 55313			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				,		
21475	Continued From page	e 74	21475			
	that she wants to kill h	nerself." LPN-A then stated,				
		e charted as often as they				
	_	R28 and R29 just, "Got into				
	it with each other in th	ne hall."				
		6/15, at 4:23 p.m. R28				
		been treated like this ever in				
	my life." R28 started present at the time of	to cry, and LPN-A (who was				
		"I have asked for a different				
		nt room, and I have told the				
		at!" R28 continued to cry				
	_	her Kleenex. R28 then				
	began rubbing her he	ad and stated, "Oh my god I				
		ave it in the back of my				
		am 86 years old, why do I				
	have to put up with th					
		nastier than nasty." At 4:33				
	p.m., R28 was still cry	/ilig.				
	During interview on 1	0/26/15, at 4:36 p.m. social				
		everyone at the facility was				
		lid not get along. SW-A				
		ector of nursing (DON) had				
	_	residents to separate				
		d not be a benefit to move				
	either one of them. S					
		made comments about a n when there hasn't been a				
		tated she was not aware if				
		B up at night, and stated she				
		her suicide thoughts and				
		plan. SW-A stated she had				
	offered to move R28	to a different room,				
	however, her daughte	er in law did not want her to				
		he facility did not currently				
	• •	ns available, and the empty				
		nates, and the facility felt				
	_	t for a private room to open				
	petore moving R28. S	SW-A stated she had not				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 75 of 105

Minnesot	<u>a Department of Health</u>	h			
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00714	00714 B. WING		10/26/2015
		•			1 10/20/2010
NAME OF PR	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	LAKE BOULEVARD		
		BUI	FFALO, MN 55313	T.	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAO		,	IAG	DEFICIENCY)	
04.475	0 " 15	75	24.475		
21475	Continued From page	e /5	21475		
	filled out a waiver for	a private room because she			
		dent was actually moved into			
		might be a couple opening ir	I		
		A stated R28 had been seen			
		inic of Psychology and they			
	were to be seeing R2	28 on a monthly basis,			
		e visit was 8/17/15, and			
	there currently was no	ot a follow up appointment			
	scheduled. SW-A sta	ated she would need to call			
	the Psychology clinic	being it had been a few			
	months, because the	Psychologist was, "Not very			
	good about keeping h	her schedule with the			
	residents here."				
	_	26/15, at 5:07 p.m. R28's			
	• • • • • • • • • • • • • • • • • • • •	A stated she was aware of			
		er roommate, and the			
	•	ain to her about it. FM-A wa	S		
		ian had recommended a			
	•	, nor had the facility spoken			
		R28 to a different or private			
	room.				
	During intension 10/2	26/15, at 6:03 p.m. DON			
	•	iff know there, "Is a clash			
		R29]." The DON stated she			
		e the social worker was at			
		ween the resident, and the			
		nination regarding resident			
		nowever, the DON stated, "I			
		y haven't moved one of			
		she heard about suicidal			
		, but was not aware R28			
		out wanting a cord for			
		d stated, "If she [R28] said			
	that, she had a plan."				
	at, one nad a plan.				
	A facility policy addres	essing the responsibilities of			
		equested but was not			

Minnesota Department of Health STATE FORM

provided.

6899 28WI11 If continuation sheet 76 of 105

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		00714	B. WING		10/26	6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		310 LAKE	BOULEVARD			
LAKE RID	GE CARE CENTER OF E	BUFFALO), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21475	Continued From page	e 76	21475			
21530	SUGGESTED METH The social worker or and/or revise facility prelated to medically in Responsible personn these policies and preefforts could be made social service needs in the deficiency, with maintained. Other refor social service need could be developed a results shared with the Assessment & Assurance on-going compliance. TIME PERIOD FOR (14) days. MN Rule 4658.1310 A. A. The drug regiment reviewed at least more currently licensed by This review must be a Appendix N of the State Surveyor Procedures Requirements in Long the Department of He Health Care Financin This standard is inconvaliable through the system. It is not subjuit of the B. The pharmacin irregularities to the diand the attending phymust be acted upon the system of the system of the diand the attending phymust be acted upon the system of the system of the diand the attending phymust be acted upon the system.	designee, could review policies and procedures elated social services. Hel could be re-educated on pocedures. Appropriate toward supporting the of the individual(s) identified in supporting documentation esidents could be evaluated eds. An auditing system and implemented, with the facility's Quality ance committee, to ensure correct to each resident Review in of each resident must be	21530			12/29/15

Minnesota Department of Health STATE FORM

Minnesot	<u>a Department of Health</u>	<u>h</u>			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	' '	(X2) MULTIPLE CONSTRUCTION (X3) DA	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STRFFT	ADDRESS, CITY, STA	TE. ZIP CODE	
			KE BOULEVARD	,	
LAKE RID	GE CARE CENTER OF E	BUFFALO	LO, MN 55313		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIENC)	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				·	
21530	Continued From page	e 77	21530		
	pharmacist. For purp	poses of this part, "acted			
		ceptance or rejection of the			
		g or initialing by the director			
		nd the attending physician.			
		g physician does not concur recommendation, or does			
	not provide adequate				
		the resident's quality of life is			
		cted, the pharmacist must			
		e medical director for review			
	if the medical director				
		dical director determines that			
		an does not have adequate			
		der and if the attending hange the order, the matter			
	must be referred for r	-			
		urance committee required			
	by part 4658.0070. If	f the attending physician is			
		the consulting pharmacist			
	must refer the matter	-			
	assessment and assu	urance committee.			
	This MN Requiremen	nt is not met as evidenced			
	by:				
	Based on interview ar	nd document review, the		Corrected.	
		e the consultant pharmacist			
		establish pain medication			
	-	vere acted upon for 1 of 5			
	residents (R5) review medication use.	ved for unfriecessary			
	medication use.				
	Findings include:				
	R5's quarterly Minimu	um Data Set (MDS) dated			
		5 had intact cognition, no			
		tensive assistance with his			
		gs (ADLs). The MDS			
	identified R5 had diag	gnoses including chronic			

Minnesota Department of Health

osteomyelitis [an infection of the bone or bone

STATE FORM 6899 28WI11 If continuation sheet 78 of 105

Minnesota Department of Health

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:		
		00714	B. WING		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		10/20/2015	
		310 LAKE	BOULEVARD	(I, ZII 00DL		
LAKE RID	GE CARE CENTER OF E	BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21530	Continued From page	e 78	21530			
	marrow] and a non-pi	ressure related foot ulcer.				
	R5's signed Physician 10/6/15, identified me including the following "Acetaminophen [medand inflammation] tab DX: [diagnosis] pain needed]." "Tramadol [narcotic-li IV [four] tablet; 50 mg The signed physician identify any parameter nursing staff should a Acetaminophen versucontrol R5's pain. R5's Consultant Phar Reviews directed the insignificant problem, staff: 8/3/15 - " [#5] Please parameters for using [versus] Tramadol?" 9/2/15 - "Repeat MMI review] 8/3/15 #5 - if 10/1/15 - "Repeat 8/3 appear to be address R5's medical record vino evidence the cons recommendations we on 8/3/15, 9/2/15, and	n Order Report dated edication orders for pain g: dication used to treat pain olet; 650 mg [milligrams] Every 4 Hours - PRN [as ke pain reliever] - Schedule g; Every 6 Hours - PRN." orders did not provide or ers or direction for when administer the us the Tramadol to help macy Drug Regimen following, "Potential by [sic] " to be acted upon by facility check if there are prn Acetaminophen vs R [medication regimen not addressed." of 15, MMR #5. Does not led." was reviewed and there was cultant pharmacist's ere acted upon as requested				
	During interview on 1	0/26/15, at 9:36 a.m.				

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 79 of 105

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	CONSTRUCTION	(X3) DATE SU	
			A. BOILDING.			
		00714	B. WING		10/20	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKE RIE	OGE CARE CENTER OF B	BUFFALO	BOULEVARD MN 55313			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	v I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
21530	Continued From page	: 79	21530			
21530	licensed practical numprovide either of the mow much pain he wo she stated established staff were treating R5 reviewed R5's EMAR administration record; established parameter medications. During interview on 1 registered nurse (RN) reviews the pharmacie each visit and update pharmacy recommendation by the parameters for R5's a was not addressed, a recommendations shoon, "That's an issue." During interview on 1 consulting pharmacist facilities a certain time his recommendations should have addressed made on 8/3/15, 9/2/1 "It should be done." A facility policy on me management was recommendation was recommended. SUGGESTED METHOM The medical director, and/or their designeer facility policies and provided and policies and provides and policies and provides and provides and provides are treatment and provides and p	se (LPN)-A stated she would nedications to R5 based on ould complain of, however, d parameters would ensure 's pain consistently. LPN-A (electronic medical) and stated there were nours for R5's as needed pain on the parameters would ensure outside the parameters were nours for R5's as needed pain on the parameters at the physician with the dations. RN-A reviewed and stated the period pain medications after ould have been followed up on the parameters of the	21530			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 80 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.	A. BUILDING:		
		00714	B. WING		10/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
I AKE RID	GE CARE CENTER OF E	310 LAKE	BOULEVARD			
	OE OAKE OENTER OF E	BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
21530	Continued From page	e 80	21530			
	personnel could be reand procedures. The individual(s) identified reviewed with recommacted upon and suppression and suppression for evaluated for appropring system could be developed with results shared with results shared with results compliance. TIME PERIOD FOR Codays.	e-educated on these policies medication regimen of the lin the deficiency could be mendations discussed and orting documentation in the pharmacy other residents could be riate response. An auditing eloped and implemented, with the facility's Quality ance committee, to ensure				
21545	A nursing home must A. Its medication percent as described Guidelines for Code of 42, section 483.25 (m the State Operations Surveyors for Long-To incorporated by refere purposes of this part, (1) a discrepanc prescribed and what is administered to reside (2) the administr medications. B. It is free of any error. A significant m (1) an error wh discomfort or jeopard safety; or (2) medication	error rate is less than five in the Interpretive of Federal Regulations, title in), found in Appendix P of Manual, Guidance to erm Care Facilities, which is ence in part 4658.1315. For a medication error means: by between what was medications are actually ents in the nursing home; or ation of expired	21545		12/29/1	5

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 81 of 105

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUITIPLE	(X2) MULTIPLE CONSTRUCTION		
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED	
				_		
		00714	B. WING		10/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			E BOULEVARD			
LAKE RID	GE CARE CENTER OF B	BUFFAL	O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21545	Continued From page	e 81	21545			
	medication error could precipitate a reoccurroxicity. All medication prescribed. An incide error report must be fithat occurs. Any sign resident reactions must physician or the physician or the resident designated represent must be made in the C. All medication prescribed. An incide report must be filled for occurs. Any significant resident reactions must physician or the physician or the resident designated represent.	ence of symptoms or ans are administered as ent report or medication illed for any medication error ifficant medication errors or ist be reported to the ician's designee and the ant's legal guardian or ative and an explanation resident's clinical record. s are administered as ent report or medication error or any medication error that ant medication errors or ist be reported to the ician's designee and the				
	by: Based on document r facility failed to ensure significant medication (R45) who had a med received the incorrect	review and interview, the e residents were free from errors for 1 of 1 residents lication error in which they dosage of insulin that pars with physical symptoms.		Corrected.		
	Findings include:					
	8/11/15, indicated the	m Data Set (MDS) dated resident was cognitively of diabetes mellitus, and injections.				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	E BOULEVARD O, MN 55313		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21545	Continued From page	e 82	21545		
21545	Review of the Buffalo report dated 4/8/15, in instructed by the clinic R45 had blood sugars milligram/deciliters (mrange 80-120 mg/dl. Review of the Allina Hwhich included physic indicated R45 was to acting insulin] as of thunits in the morning. now." The Lake Ridge Care Order (PO) Report da Lantus 37 units subcomparts and the PO did not direct dose of Lantus. An Allina Health office indicated R45 was to at bedtime." Howeve R45 had been receiving as the resident had of units in the morning. units more of insulin, receiving. The facility increase in insulin R4 Allina physician. Review of R45's Diab 4/1/15, to 4/30/15, indin the morning. Howell HS (at bed time), was the Lantus 37 units in R45's dose of insulin. Administration History.	Clinic Telephone order ndicated the facility was a to notify the physician if a below 80 ng/dl), normal blood sugar dealth Clinic Buffalo note cian orders dated 4/16/15, "Continue Lantus [long ne last dosage which was 37 No night time dosage for a Center signed Physician ated 4/20/15, indicated utaneous once in morning. It is staff to give a night time a visit note dated 4/20/15, go, "Back on lantus 37 units or, there was no indication ng Lantus at bedtime prior, nly been taking Lantus 37 Although this PO added 37 than R45 was currently did not clarify the significant of the staff to give a night time service of the significant of t	21545		
	Administration History				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 83 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	E BOULEVARD		
	Г		O, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21545	Continued From page	e 83	21545		
	Review of R45's Lake Report identified on 4 blood glucose was or deciliter). Review of indicate the physician blood sugar, nor did tresidents insulin had R45's Resident Progrindicated the resident checked when the resident of the low blood sugar the residents insulin had residents insulin had 845's Resident Progrindicated the was 51 mg/dl. Review not indicate the physiblood sugar, nor did tresidents insulin had R45's Resident Progrindicate the physiblood sugar, nor did tresidents insulin had R45's Resident Progring 8:33 a.m. indicated, "sugar) this morning; with the sugar that a BS of 38." 8:44 a.m. and update	e Ridge Care Center Vitals 4/22/15, at 7:44 a.m. R45's aly 52 mg/dl (milligrams per the medical record did not a was notified of the low the facility identify the been doubled on 4/20/15. Tess Note dated 4/25/15, at solve was eating breakfast dl. Review of the medical the the physician was notified ar, nor did the facility identify that been doubled on the residents blood glucose where the medical record did to the facility identify the been doubled on 4/20/15. Tess Note dated 4/26/15, at the residents blood glucose where the facility identify the been doubled on 4/20/15. Tess Note dated 4/27/15, at Resident had low BS (blood was sweating and shaky. The physician was called at the don R45's low blood sugar.			
	indicated on 4/27/15, called the clinic regar morning of 38 mg/dl. Communication form Ridge called the clinic patient should actuall	The Telephone indicated at 4:46 p.m. Lake back wanting to know if the beginning to be on 37 units of Lantus at ty just noticed the insulin			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 84 of 105

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		00744	B. WING		40/0	C/204 <i>E</i>
		00714			10/2	6/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	310 LAKE I BUFFALO,	BOULEVARD			
	QUILLEN/ QT	<u> </u>				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21545	Continued From page	e 84	21545			
	4/27/15, medical doct p.m., "Discussed with 4/20/15, visit had writ units at bedtime, whe daily MORNING DOS patient has been recedaily since the last vis sugars." MD-B order daily in the morning a R45's Resident Progr 5:37 p.m. indicated, "Lantus 37 units BID (miscommunication wrappointment. Spoke dose has been d/c'd [continue the 37 units T.O. (telephone order During interview 10/2 nursing (DON) stated insulin medication err R45, and stated she wredication error reponurses should have context they noted the order fon 4/20/15, since the that dose before, and current insulin she was stated that she had no residents orders to see problem. DON stated training related to the because she was not until survey on 10/26/error occurred.	6/15, at 9:30 a.m. director of she was not aware of the or that had occurred for was unable to locate a rt. The DON stated the alled the physician when for Lantus to be given at HS resident had not received the order was doubling the as receiving. The DON				

Minnesota Department of Health STATE FORM

6899 28WI11 If continuation sheet 85 of 105

Minnesota Departmen	t of Health	า			
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	-	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00714	B. WING		10/26/2015
NAME OF PROVIDER OR SU	PPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE	
LAKE RIDGE CARE CEN	NTER OF B	BUFFALO	AKE BOULEVARD ALO, MN 55313		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
the order to 4/20/15, the physician that HS, nor downers and the physicial insulin dose a low blood symptoms. I looked at othe prevent other suggistions and/or revisions related to make the physicial insulin dose a low blood symptoms. I looked at other prevent other suggistions and/or revisions related to make the procedures individual(s) reviewed for supporting the control of the physician and administration of the physician and the physic	only, and he double the facility fare addition lid the facility for a facility processed and additional processed lidentified in could be of this signification in ground be of this signification in ground be of the facility for accuracy documentation and implementation of the facility is action in a facility is action in a facility is action in a facility in accordance of the facility is action in a facility is action in a facility is action and implementation. A facility is Qualification in the facility is Qualification in the facility is Qualification.	had a history of low BS after re residents insulin dose on illed to clarify with the nal order of Lantus 37 units illity contact the physician pood sugars on 4/22/15, The facility did not contact 27/15, 7 days after R45's bled, when the resident had 38 and experienced e was no indication they ents, and educated staff to al medicaiton errors. OD OF CORRECTION: g or designee, could review policies and procedures administration, preventing a errors and/or medication es. Responsible personnel on these policies and dication regimen for the did in the deficiency could be and appropriateness, with atton maintained. An ecompleted to determine the inficant medication error, implemented to prevent curring in the future. The of other residents could be mented, with results shared lity Assessment & e., to ensure on-going	21545		

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN OF COR	ALCTION	IDENTIFICATION NUMBER.	A. BUILDING: _		
					OOMI LETED
		00714	B. WING		10/26/2015
NAME OF PROVIDE	R OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		310 LAKE E	BOULEVARD		
LAKE RIDGE CA	RE CENTER OF B	BUFFALO,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21800 Cont	inued From page	e 86	21800		
	St. Statute144.65 dents of HC Fac.	1 Subd. 4 Patients & Bill of Rights	21800		12/29/15
resident are I stay treat that writted respective as destated persection persection according to the vestion according to	ents shall, at adregal rights for the at the facility or the ment and mainted these are describen statement of the onsibilities set for of patients admired in section 25 and 16 years old on 16 years old on 16 years old on 16 years old on ded in section 25 list the names an iduals and organicacy and legal sential programs. In a modation shamming the policies, inspectively administrator of on, consistent with the policies administrator of on, consistent with the policies and section and se	in about rights. Patients and mission, be told that there eir protection during their hroughout their course of mance in the community and red in an accompanying me applicable rights and the thin this section. In the tted to residential programs 253C.01, the written describe the right of a rolder to request release as 63B.04, subdivision 2, and and telephone numbers of dizations that provide dervices for patients in Reasonable and those who were than English. Current cition findings of state and so, and further explanation of of rights shall be available their guardians or their resupen reasonable request of the chapter 13, the Data cition 626.557, relating to		Corrected.	

Minnesota Department of Health STATE FORM

ATE FORM 28WI11 If continuation sheet 87 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUILDING.			
		00714	B. WING		10/26/	2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
	CUMMARYCT		, MN 55313	PROVIDENCE DI AN OF CORRECTIO	NI .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21800	Continued From page	e 87	21800			
		quired notice of Medicare ermination of the covered				
	Findings include:					
	Report dated 4/15/15 was admitted with a pure "Medicare Part A," and 32 days. R98's medical record information was identification.	eave/Discharge Tracking to 5/25/15, identified R98 cayment source of, and remained in the facility for was reviewed, however, no tified she had been provided of Medicare non-coverage				
	During interview on 1 worker (SW)-A stated evidence R98 was pr Provider Non-Covera admitted for a therap	0/26/15, at 2:14 p.m. social there was no documented ovided a Notice of Medicare ge (CMS-10123). R98 was y stay at the facility, and ren the denial notice two	S			
	p.m., SW-A stated the policy on ensuring the	rview on 10/26/15, at 2:55 e facility did not have a e liability notices were given "Just follow Medicare				
	The social worker or and/or revise facility prelated to liability and Medicare non-covera	al(s) identified in the				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 88 of 105

Minnesota Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED
			D MINIO			
		00714	B. WING		10	0/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
I AKE RID	GE CARE CENTER OF E	SUFFALO 310 LAKI	E BOULEVARD			
	OL OAKE GENTER OF E	BUFFALO	O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21800	Continued From page	e 88	21800			
	with the facility's Qua Assurance committee compliance.	mented, with results shared lity Assessment &				
21830	Residents of HC Fac.	ion in planning treatment;	21830			12/29/15
	(a) Residents shall hin the planning of thei includes the opportunal ternatives with indivopportunity to reques care conferences, and family member or oth both. In the event that present, a family men chosen by the resident conferences. (b) If a resident who unconscious or coma communicate, the fact efforts as required uneither a family member writing by the resident an emergency that the admitted to the facility family member to par planning, unless the football to believe the resident directive to the contract.	nave the right to participate r health care. This right ity to discuss treatment and idual caregivers, the t and participate in formal d the right to include a er chosen representative or at the resident cannot be hiber or other representative int may be included in such o enters a facility is tose or is unable to illity shall make reasonable der paragraph (c) to notify er or a person designated in t as the person to contact in e resident has been or. The facility shall allow the				

Minnesota Department of Health STATE FORM

	a Department of Health				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00714	B. WING		10/26/2015
					1 10/20/2013
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STA	TE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE			LAKE BOULEVARD		
LAKE KID	OL CARL CLIVILIC OF L	BUF	FALO, MN 55313		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE DATE
21830	Continued From page	e 89	21830		
	member included in to	reatment planning. After			
		mber but prior to allowing a			
	family member to par				
	,	nust make reasonable			
		h reasonable medical			
	practice, to determine				
		e directive relative to the			
		decisions. For purposes of			
		onable efforts" include:			
		personal effects of the			
	resident;				
	(2) examining the r	medical records of the			
	resident in the posses	ssion of the facility;			
	(3) inquiring of any	emergency contact or			
	family member contact	cted under this section			
	whether the resident	has executed an advance			
	directive and whether	r the resident has a			
	physician to whom the	e resident normally goes for			
	care; and				
		physician to whom the			
	resident normally goe				
		has executed an advance			
	•	notifies a family member or	1		
	_	cy contact or allows a family			
		e in treatment planning in			
		paragraph, the facility is not			
		damages on the grounds tha	t		
	the notification of the				
		r the participation of the mproper or violated the			
	patient's privacy right				
		onable efforts to notify a			
		signated emergency contact			
	the facility shall attem		'		
	-	ated emergency contact by			
		nal effects of the resident			
	• .	rds of the resident in the			
		ility. If the facility is unable			
	to notify a family men				

Minnesota Department of Health STATE FORM

Minnesota Department of Health	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	
00714 B. WING 10/26/2015	
10/20/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUFFALO	
BUFFALO, MN 55313	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	·
	-
21830 Continued From page 90 21830	
emergency contact within 24 hours after the	
admission, the facility shall notify the county	
social service agency or local law enforcement	
agency that the resident has been admitted and	
the facility has been unable to notify a family	
member or designated emergency contact. The	
county social service agency and local law	
enforcement agency shall assist the facility in	
identifying and notifying a family member or	
designated emergency contact. A county social	
service agency or local law enforcement agency	
that assists a facility in implementing this	
subdivision is not liable to the resident for	
damages on the grounds that the notification of	
the family member or emergency contact or the	
participation of the family member was improper	
or violated the patient's privacy rights.	
This MN Requirement is not met as evidenced	
by:	
Based on interview and document review, the Corrected.	
facility failed to honor bathing preferences for 1 of	
3 residents (R73) reviewed for choices.	
Findings include: P73's admission Minimum Data Set (MDS) dated	
R73's admission Minimum Data Set (MDS) dated 10/1/15, indicated he was cognitively intact,	
needed assist of two staff with bathing, and it was	
"very important" to be able to chose the method in	
which he was bathed.	
R73's care plan dated 9/25/15, identified he had	
been admitted in September 2015, but did not	
identify any preferences or assistance R73	
required with bathing. R73's undated Nursing	
Assistant Care Sheet indicated he received a tub	
Assistant Care Sheet indicated he received a tub bath on Thursday by an outside agency.	
Assistant Care Sheet indicated he received a tub	

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 91 of 105

Minnesota Department of Health		_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00714	B. WING		10/26/2015
NAME OF D	ROVIDER OR SUPPLIER	QTDEET AF	DRESS, CITY, STA	TE ZID CODE	
NAME OF T	TOVIDEIX OIX OOI I EIEIX		BOULEVARD	KIE, ZII GOBE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	D, MN 55313		
()(1) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE DATE
				BEI IGIEROT)	
21830	Continued From page	e 91	21830		
		. R73 then stated, "I have			
	_	hs from the facility since I			
	have been here."				
		ek Bridge Weekly Bath and			
	following:	15 to 10/22/15, identified the			
		5 to 9/27/15, R73 was not			
	identified on the bath				
		5 to 10/4/15, R73 continued			
	to not be identified on				
		5 to 10/11/15, R73 was			
		four baths, but only had one			
	bath documented as	being completed. 15 to 10/18/15, R73 was			
		eceive four baths, but only			
	_	ented as being completed.			
		15 to 10/22/15, R73 was			
	scheduled to receive	three baths, but only had			
		ed as being completed.			
	_	ified R7 received two baths			
	-	wo baths from the outside ut of the 11 baths he should			
	have received.	at of the 11 baths he should			
		3/15, at 9:15 a.m. nursing			
		ed the staff do the best they			
		do not have a bath aide and			
		f them done so some of the			
		sed. That's all I can say."			
	_	3/15, at 9:21 a.m. registered			
		R73 should have received his choice adding if it was			
	not documented on th				
	completed.	,			
	•	oices was requested, but			
	none was provided.				
	SUGGESTED METH	OD OF CORRECTION:			
		g or designee, could review			
		policies and procedures			
	related to resident che	oice and participation in			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 92 of 105

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKE RIDGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES BY FALO BUFFALO BUFFALO BUFFALO, MN 55313 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY COMPLETED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY COMPLETED B		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 92 planning of their bathing schedules. Responsible personnel could be re-educated on these policies and procedures. Appropriate accommodations could be made to honor the bathing preferences of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for preferences with regard to their bathing schedules. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30)							
CAU ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG			00714	B. WING		10/2	26/2015
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 21830 Continued From page 92 21830 21830	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 92 planning of their bathing schedules. Responsible personnel could be re-educated on these policies and procedures. Appropriate accommodations could be made to honor the bathing preferences of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for preferences with regard to their bathing schedules. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30)	LAKE RID	GE CARE CENTER OF E	BUFFALO				
planning of their bathing schedules. Responsible personnel could be re-educated on these policies and procedures. Appropriate accommodations could be made to honor the bathing preferences of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for preferences with regard to their bathing schedules. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30)	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETE DATE
MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide timely follow-up to the resident council groups grievance as concerned with inadequate staffing in the facility. This affected 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15. Findings include: During the recertification survey, the resident council minutes were reviewed and identified the following:		planning of their bathing personnel could be reand procedures. App could be made to hor of the individual(s) ide with supporting docur residents could be evergard to their bathing system could be deve with results shared with assessment & Assura on-going compliance. TIME PERIOD FOR Codays. MN St. Statute 144.68 Residents of HC Fac. Subd. 18. Responsi residents shall have to the reasonable response requests. This MN Requirement by: Based on interview and facility failed to provide resident council group with inadequate staffing affected 5 of the 48 recouncil meetings from Findings include: During the recertificate council minutes were	ing schedules. Responsible e-educated on these policies propriate accommodations for the bathing preferences entified in the deficiency, mentation maintained. Other aluated for preferences with g schedules. An auditing eloped and implemented, with the facility's Quality ance committee, to ensure a committee, to ensure a committee. The property of the right to a prompt and to their questions and to their questions and the timely follow-up to the post grievance as concerned and in the facility. This esidents (R27, R19, R45, regularly attended resident in 7/28/15 to 9/29/15.				12/29/15

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 93 of 105

Minnesot	Minnesota Department of Health							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED		
		00714	B. WING		10/2	6/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE				
LAKE DID	OF CARE OF MED OF F	310 LAKE	BOULEVARD					
LAKE KID	GE CARE CENTER OF E	BUFFALO	O, MN 55313					
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE		
,,,,		,	,,,,,	DEFICIENCY)				
21870	Continued From page 93		21870					
21070			2.070					
		ng R27, R19, R45, "All feel						
		gh nursing help due to how						
	Writer [activity director	call lights to be answered.						
		utting hours due to census						
		ort staffed." The minutes						
		scussion, input from the						
	_	ment of a plan to address						
	R27, R19, and R45's	voiced concerns with						
		Resident Council Action						
		from the director of nursing						
		sponse which identified,						
		ne day and night when many						
		ting assistance at the same						
		to each one of them as e are adequately staffed.						
		new and work a little slower						
	while they are learning							
		minutes dated 8/13/15,						
	identified, "Updates o	on last meeting concerns"		\ \ \ \				
		ever R27, R21, R19 and						
		I [residents] state we are						
		assistant help. They feel we	1					
	_	staff. Writer [AD] explained it						
		usiness for nurse assistants						
	_	ually have another person le helping someone." The						
	_	urther discussion, input from						
	the residents, or deve							
		19, R35, and R45's voiced						
		g. A follow up Resident						
		dated 8/25/15, completed as						
		ON indicated, "We continue						
		employees continuously						
		nank You [underlined several						
		f a smiley face drawn next to						
	it]!"							
		minutes dated 9/29/15,						
	identified, Council m	embers are concerned						

Minnesota Department of Health

about staffing. Writer [AD] explained staffing.

STATE FORM 8899 28WI11 If continuation sheet 94 of 105

Minnesot	a Department of Health	າ			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		00714	B. WING		10/26/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE	
LAKE RID	GE CARE CENTER OF E	BUFFALO	E BOULEVARD		
	-	BUFFALO	O, MN 55313		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21870	Continued From page 94		21870		
	for too long. Writer enequirement for a NAI registered] to be able need assist to eat and reason he had to wait the repeated concern staffing at the facility management team. During interview on 1 stated she did not feet the council meetings. "They are so short stated she did not feet the council meetings." They are so short stated she did not feet the council meetings. "They are so short stated she did not feet the council meetings." They are so short stated she is not to help me you see I at to get on the bed pan movement] and when I have an accident in pleasant for me." During interview on 1 who stated she is in a council meetings. All complain about the staffing continued at the staffing continued at the 8/13 council meetings with plan being identified the staffing. The facility Grievance dated 1/12/12, indicated 1/12/12, indicated Ridge Care Center to that enhances resident.	R's [nursing assistant, to sit with residents who do that this way likely the it." There was no evidence is regarding inadequate were addressed by the 10/23/15, at 12:23 p.m. R45 all the concerns voiced during were addressed, adding, affed here at the facility wait 45 minutes for the staff am immobile and need help to have a BM [bowel in they are late, I can't wait so the bed and that is not 10/23/15, at 9:30 a.m. the AD charge of the resident to stated, "The residents do			

Minnesota Department of Health

the opportunity to voice their concerns to improve

STATE FORM 6899 28WI11 If continuation sheet 95 of 105

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
		00714	B. WING		10/2	26/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
		BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21870	Continued From page	95	21870			
21880	resident, their represe advocate has a conce treatment, property or encouraged to bring to of the appropriate deposition of the director of nursing and/or revise facility prelated to resident concepts and properties	chat concern to the attention coartment manager." OD OF CORRECTION: g or designee, could review colicies and procedures uncil grievances. el could be re-educated on cocedures. Appropriate con of resident council made, with supporting cained. An auditing system and implemented, with e facility's Quality cance committee, to ensure	21880			12/29/15
21880	MN St. Statute 144.69 Residents of HC Fac.	51 Subd. 20 Patients & Bill of Rights	21880			12/29/15
	shall be encouraged at their stay in a facility of to understand and expatients, residents, arresidents may voice of changes in policies and others of their chinterference, coercior including threat of disgrievance procedure	nd citizens. Patients and grievances and recommend nd services to facility staff oice, free from restraint, n, discrimination, or reprisal,				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 96 of 105

Minnesota Department of Health

Minnesot	a Department of Healtr	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF D	ROVIDER OR SUPPLIER	etheet And	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	KIE, ZII GODE		
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD			
			MN 55313	I		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
21880	Continued From page 96		21880			
	Office of Health Facil	lity Complaints and the area				
		sman pursuant to the Older				
	Americans Act, section					
	posted in a conspicuo	, , ,				
	•	npatient facility, every				
	residential program a					
	253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that,					
	at a minimum, sets fo		,			
		ne limits, including time				
		onse; provides for the patient				
	or resident to have th					
		written response to written				
	_	des for a timely decision by				
		maker if the grievance is not				
		Compliance by hospitals,				
	residential programs					
	253C.01 which are ho	and outpatient surgery				
		44.691 and compliance by				
		organizations with section				
		be compliance with the				
	requirement for a writ	ten internal grievance				
	procedure.	•				
	This MN Poquiromon	t is not met as evidenced				
	by:	t is not met as evidenced				
		nd document review, the		Corrected.		
		pt to resolve an individual		3330.00.		
		esidents (R45) who had				
	•	over lift placement and				
	bruising.	•				
	-					
	Findings include:					

Minnesota Department of Health STATE FORM

Minnesota Department of Health

winnesot	a Department of Healtr	<u>1</u>	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00714	B. WING		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE ZIP CODE		
			BOULEVARD	, 0002		
LAKE RID	GE CARE CENTER OF E	BUFFALO	, MN 55313			
()(1) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	ı	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
			1	DEFICIENCY)		
21880	Continued From page	e 97	21880			
	R45's annual Minimu	m Data Set (MDS) dated				
		5 was cognitively intact and				
		of two staff for transfers.				
	A Resident Council A	ction Form dated 8/12/15,				
		ad complaints that when she				
	,	a nurse she feels they do				
		Had concerns about lift				
		and bruising [R45] felt she				
	wasn't taken seriously					
	_	to the DON. The form of nursing (DON) response:				
	"[R45] was not feeling					
		with illness. this writer did				
	visit with her and that					
	concern."					
		•				
		0/22/15, at 2:10 p.m. the				
		aware of R45's concern but				
		ig deal. The DON stated it never investigated if there				
		he staff were transferring				
		N had not implemented any				
		solve R45's concern with the				
	lift.					
		0/23/15, at 12:23 p.m. with				
		lid not always listen to her				
		ncern. R45 stated a few				
		e was being transferred from				
	her ceiling lift, the stra	-				
	correctly and it slid do causing a skin tear ar					
		e "made a grievance in				
		didn't "think anything was				
	done about it."	, , , , , , , , , , , , , , , , , , ,				
	A facility Grievances	and Complaints policy dated				
	1/12/12, indicated, "It	is the policy of Lake Ridge				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 98 of 105

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
			A. BOILDING.			
		00714	B. WING		10/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
	OLUMBA DV OT		MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21880	Continued From page	98	21880			
	enhances resident dig peace of mind by allo opportunity to voice the facility." Further, the resident, their represe advocate has a concentreatment, property of encouraged to bring the of the appropriate deposition of the director of nursing and/or revise facility prelated to individual reflected to individual reflec	entative, family member or ern with any aspect of care, or the facility; they are that concern to the attention coartment manager." OD OF CORRECTION: g or designee, could review colicies and procedures esident grievances. el could be re-educated on cocedures. Grievances could individual(s) identified in the corting documentation sidents could be evaluated the evaluated could be developed and soults shared with the facility's Assurance committee, to				
21980	MN St. Statute 626.58 Maltreatment of Vulne	57 Subd. 3 Reporting - erable Adults	21980			12/29/15
	reporter who has reas vulnerable adult is be or who has knowledg has sustained a phys reasonably explained	report. (a) A mandated son to believe that a ing or has been maltreated, e that a vulnerable adult ical injury which is not shall immediately report the				

Minnesota Department of Health STATE FORM

28WI11 If continuation sheet 99 of 105

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING	B. WING		6/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		,
LAKE DID	OF CARE CENTER OF F	310 LAKE	BOULEVARD			
LAKE KIL	GE CARE CENTER OF E	BUFFALO,	MN 55313			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21980	Continued From page	99	21980			
21900	individual is a vulnerathe individual is admirreporter is not require maltreatment of the into admission, unless: (1) the individual was another facility and the believe the vulnerable previous facility; or (2) the reporter known that the individual is a in section 626.5572, (b) A person not reprovisions of this section 626.5572, (c) Nothing in this sknown or suspected reprovisions of the corresponding in the correspondin	admitted to the facility from the reporter has reason to the adult was maltreated in the sows or has reason to believe a vulnerable adult as defined subdivision 21, clause (4), quired to report under the stion may voluntarily report to know that a report has mon entry point. Section shall preclude a porting to a law enforcement to corter who knows or has an error under section 17, paragraph (c), clause the areport under this porter or a facility, at any investigation by a lead to or should determine that as not neglect according to the common entry point or the criteria under section 17, paragraph (c), clause 18, paragraph (c), clause 19, paragraph (c), clause	21900			

Minnesota Department of Health STATE FORM

6899

Minnesota Department of Health

WIIIIIICSOL	a Department of Fleatti	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00714	B. WING		10/20	6/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	I E, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD			
		BUFFALO,	MN 55313			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
21000	Continued From none	. 400	21980			
21980	Continued From page	9 100	21960			
	the report under subd	ivision 9c.				
	· · · · · · · · · · · · · · · · · · ·	t is not met as evidenced				
	by:					
	Based on interview and document review, the			Corrected.		
	facility failed to ensure allegations of abuse, neglect and injuries of unknown origin were					
		to the administrator, state				
		ly investigated for 3 of 5				
	residents (R45, R104					
	allegations were revie		,			
	Findings include:					
	J					
	R45's annual Minimur	m Data Set (MDS) dated				
	8/11/15, indicated she	was cognitively intact and				
	required assist of two	staff with transfers.				
	A Booldont Council A	ction Form dated 8/12/15,				
		ad complaints that when she				
		a nurse she feels they do				
	-	" R45 had "concerns about				
	-	nt and bruising," and, "felt				
		ously." The form identified it				
		I who responded, "Res				
	[resident] was not fee	•				
		vith illness did visit with				
	her and that she down	n played the concern."				
	During interview 10/2:					
	• ,	ON) stated she was aware				
		didn't feel it was of concern.				
		s concern with the lift was				
		cluding if there was bruising				
		transferring the resident,				
		the State agency. Further, was was not aware of any				
		vas was not aware or any				
	bruising on R45.					

Minnesota Department of Health STATE FORM

28WI11

Minnesota Department of Health

	a Department of Fleatt		0.00 1.00 7.00 5	CONTRICTION	Taray BATE OF	ID) (E) (
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
AND LONG	S. SSIGNESTION	.BERTH 10/ RICH HOWBER.	A. BUILDING:			0
		00714	B. WING		10/26	6/2015
NAME OF D	DOVIDED OD SUDDI IED	STDEET AD	DDESS CITY ST	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	II E, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
		BUFFALC	D, MN 55313			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORI GIVE	EGO IDENTIL TING INI GRANATION)	TAG	DEFICIENCY)	WATE	
			1			
21980	Continued From page	e 101	21980			
	During interview 10/2	3/15, at 12:23 p.m. R45				
		always listen to her when				
		that they (staff) can be				
		ne was being assisted to				
		s prior, and the strap used by				
		t attached correctly which				
	_	n and cause a skin tear and				
	bruising on her arm.	R45 stated she was				
		iring the transfer, she yelled				
		ne staff did not stop the				
	transfer. The staff proceeded to transfer her,					
	despite her cries of pa					
	Although R45 reporte	ed during a transfer of staff				
	being rough causing a	a skin tear and bruising				
	there was no indication	on the adminstrator and the				
	state agency were im	mediately notifed, nor had				
	an investigation been	completed of the allegation.				
		OS dated 6/11/15, indicated				
	he was cognitively int	act and feels depressed.				
		ted 6/29/15, indicated that				
		room, "Writer got to the door				
		is loud voice that was not				
		wearing. Writer was unable				
		peing said but did her the				
		ur and Asshole" in an angry				
		immediately went into room				
		esident's family member				
		resident. Resident was				
		M-A to leave. Resident said				
	•	d to leave several times by				
		olied with leaving. FM-A at				
		up his phone that had a light				
	-	ards resident. Resident was				
		s video taping him. Resident				
		ked residnet if FM-A had his				
	permission to do this	and resident stated "no".				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 102 of 105

Minnesota Department of Health

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU	
			A. BUILDING:			
	00714		B. WING		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF B	BUFFALO	BOULEVARD , MN 55313			
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
21980	Continued From page 102		21980			
21980	Resident also stated to been physically abusing threatened to kill him residents home. Residents home to try to kill him to show for it. Residents how if he wanted FM since he has been the helping him. Resident FM-A now had keys to refusing to give those resident, "you will have you think you are going also stated FM-A has give that back. The into the state agency of During interview 10/20 DON who stated the immediately reported had been reported late. Although the incident facility did not report to administrator and state after the incident, on the state agency of R131's quarterly MDS she was moderately content of the state as sist of two states and the state agency of the st	that (FM-A) has, in the past, we to him and has also in the past while at dent stated that FM-A had no a bonfire at residents, and he still had the scars ent express that he didn't M-A back here at the facility e only one that has been t also let writer know that to his home, truck and was back. FM-A told the we to break into your house if ng back there". Resident his laptop and refusing to investigation was submitted in 7/01/15. 6/15, at 6:13 p.m. with the incident should have been and she did not know why it e. occurred on 6/26/15, the the incident to the te agency until two days 6/29/2015.	21980			
	that on 4/3/15 R131 h area to the lateral left cm (centimeter) by 8 reassessed for her ab transferred in this type					

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 103 of 105

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE	
		00714	B. WING		10/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	BUFFALO	BOULEVARD			
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	, MN 55313	PROVIDER'S PLAN OF CORRECTION	N.	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21980	Continued From page 103		21980			
21980	The administrator and informed of the incide and the investigation agency on 4/13/15, 10 occurred and identifies mechanical lift. During interview 10/2 stated the investigation know why it was sent computer glich". Furt because of the size an eeded to be reported. Although the injury was facility failed to inform the state agency two investigation was not. The facilities Vulneral Policy and Procedure indicated "Each employsuspected/alleged vicabuse/neglect immed following: Nursing sup Director of Nursing, of administrator will be rether above. Staff may Administrator if desire violations and substatif immediately to the state agencies as required (common entry point) (Minnesota Department further indicated "All reformed indicated" All reformed indicated "All reformed indicated" and indicated i	d the state agency was ent on 4/5/15 two days later was submitted to the state 0 days after the incident ed the injury was from a 2/15, at 2:17 p.m. DON on was sent late and didn't late "maybe it was a ther, the DON stated and the location, the incident d. as noted on 4/3/15, the anthe administrator and and days later and the reported until 10 days later. Die Adult Abuse Prohibition revised November 2011, oyee is responsible to report plations of resident liately to one of the pervisor, Nurse on Duty, or Social Worker. The motified immediately by on of ago immediately to the ed. Report all alleged antiated incidents are agency and all other (oral report to CEP and electronically to MDH ent of Health)." The policy reports of resident abuse, funknown source shall be	21980			
	SUGGESTED METH	OD OF CORRECTION:				

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 104 of 105

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00714	B. WING		10/26/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LAKE RID	GE CARE CENTER OF E	310 LAKE I BUFFALO,	BOULEVARD			
0/0/15	SHWWWDV ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N.	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21980	Continued From page	e 104	21980			
21980	The director of nursin and/or revise facility prelated to abuse prohpersonnel could be reand procedures. Repinjuries of unknown o compliance with these documentation maintacould be developed a results shared with the Assessment & Assuraon-going compliance.	g or designee, could review policies and procedures ibition. Responsible e-educated on these policies ports of abuse/ neglect/ rigin could be reviewed for e policies, with supporting ained. An auditing system and implemented, with e facility's Quality ance committee, to ensure	21980			

Minnesota Department of Health

STATE FORM 8899 28WI11 If continuation sheet 105 of 105

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	Γ
IDENTIFICATION NUMBER	A. Building			
00714 _{Y1}	B. Wing	Y2	1/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF	BUFFALO	310 LAKE BOULEVARD		
		BUFFALO, MN 55313		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20130		Correction	ID Prefix	20255		Correction	ID Prefix	20265		Correction
Reg.#	MN Rule 4658.005 Subp. 1	50	Completed	Reg.#	MN Rul	e 4658.0070	Completed	Reg. #	MN Rule 4658.008	35	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	20565		Correction	ID Prefix	20800		Correction	ID Prefix	20830		Correction
Reg.#	MN Rule 4658.040 Subp. 3)5	Completed	Reg. #	MN Rul Subp. 1	e 4658.0510	Completed	Reg. #	MN Rule 4658.052 Subp. 1	20	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	20840		Correction	ID Prefix	20860		Correction	ID Prefix	20910		Correction
Reg.#	MN Rule 4658.052 Subp. 2 B	20	Completed	Reg.#	MN Rul Subp. 2	e 4658.0520 ! F.	Completed	Reg.#	MN Rule 4658.052 Subp. 5 A.B	25	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	21330		Correction	ID Prefix	21375		Correction	ID Prefix	21426		Correction
Reg.#	MN Rule 4658.072 Subp. 2 A&B	25	Completed	Reg.#	MN Rul Subp. 1	e 4658.0800	Completed	Reg. #	MN St. Statute 144 Subd. 3	1A.04	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	21475		Correction	ID Prefix	21530		Correction	ID Prefix	21545		Correction
Reg.#	MN Rule 4658.100 Subp. 1)5	Completed	Reg.#	MN Rul A.B.C	e 4658.1310	Completed	Reg. #	MN Rule 4658.132 A.B.C	20	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
REVIEWE STATE AG		REVIEWE (INITIALS	ED BY BF/mm	DATE 12/06/2	016	SIGNATURE OF SU	RVEYOR 35575			DATE 01/21	/2016
REVIEWE CMS RO		REVIEWE (INITIALS	ED BY	DATE		TITLE				DATE	

Page 1 of 2 EVENT ID: 28WI12

STATE FORM: REVISIT REPORT PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 00714 B. Wing 1/21/2016 Y3 NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y4 Y5 Y5 Y4 Y4 Y5 Correction ID Prefix 21800 ID Prefix 21830 Correction **ID Prefix** 21870 Correction MN St. Statute144.651 MN St. Statute 144.651 MN St. Statute 144.651 Reg. # Completed Reg. # Completed Completed Reg. # Subd. 4 Subd. 10 Subd. 18 12/29/2015 12/29/2015 12/29/2015 LSC LSC LSC 21980 **ID Prefix ID Prefix** 21880 Correction Correction MN St. Statute 626.557 MN St. Statute 144.651 Reg. # Completed Reg. # Completed Subd. 20 Subd. 3 12/29/2015 12/29/2015 LSC LSC DATE **REVIEWED BY REVIEWED BY** SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) X BF/mm 12/06/2016 35575 01/21/2016 TITLE DATE **REVIEWED BY REVIEWED BY** DATE CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF **FOLLOWUP TO SURVEY COMPLETED ON** UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 10/26/2015 YES □ №

Page 2 of 2 EVENT ID: 28WI12

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 28WI

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Fa	cility ID: 00714
MEDICARE/MEDICAID PROVIDER (L1) 245513 STATE VENDOR OR MEDICAID NO.		3. NAME AND AD (L3) LAKE RIDG (L4) 310 LAKE B	E CARE CENTI		FALO	4. TYPE OF ACTION: 1. Initial	7 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 066663700		(L5) BUFFALO, N			(L6) 55313	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 02/01/2004	VNERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR 05 HHA	Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	1/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING I	DATE: (L35)
2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a): To (b):		X A. In Complian Program Re Compliance	nce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	Following Requirements: 6. Scope of Service 7. Medical Director	es Limit
12.Total Facility Beds 13.Total Certified Beds	56 (L18) 56 (L17)	B. Not in Com	acceptable POC pliance with Progran and/or Applied Waiv		4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A*	8. Patient Room Si 9. Beds/Room (L12)	ze
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 56	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LIC CANCELL	AHON DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL	Date:
Jennifer Ba	hr, HFE NE	II	01/21/2016	(L19)	Kate JohnsTon, Pro	ogram Specialist	01/28/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SINGLE STAT	TE AGENCY	
19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa 2. Facility is not Eligible			IPLIANCE WITH C HTS ACT:	CIVIL	21. 1. Statement of Financi2. Ownership/Control I3. Both of the Above :	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-	1513)
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L	30)
OF PARTICIPATION 02/01/1988	BEGINNING I	DATE	ENDING DAT	Е	VOLUNTARY 00 01-Merger, Closure	05-Fail to Med	et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination		et Agreement
25. LTC EXTENSION DATE:	A. Suspension of		(L44)		04-Other Reason for Withdrawal	OTHER 07-Provider S 00-Active	tatus Change
(L27)	B. Rescind Sus	pension Date:	(L45)				
28. TERMINATION DATE:	29	INTERMEDIARY/C			30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (OF APPROVAL DA	ГЕ	Posted 02/12/2016 Co.		

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245513 January 28, 2016

Mr. Jason Nelson, Administrator Lake Ridge Care Center of Buffalo 310 Lake Boulevard Buffalo, Minnesota 55313

Dear Mr. Nelson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 29, 2015 the above facility is certified for or recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Lake Ridge Care Center Of Buffalo January 28, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered January 28, 2016

Mr. Jason Nelson, Administrator Lake Ridge Care Center of Buffalo 310 Lake Boulevard Buffalo, Minnesota 55313

RE: Project Number S5513025 & H5513019

Dear Mr. Nelson:

On November 19, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 24, 2015. (42 CFR 488.422)

On December 3, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of \$2000.00 for the deficiency cited at F250, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$2000.00 for the deficiency cited at F309, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$5700.00 for the deficiency cited at F323, (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 26, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on October 26, 2015 that included an investigation of complaint number H5513019. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On January 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 29, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on October 26, 2015, as of December 29, 2015.

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

Lake Ridge Care Center Of Buffalo January 28, 2016 Page 2

effective December 29, 2015.

However, as we notified you in our letter of November 19, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 3, 2015:

- Per instance civil money penalty of \$2000.00 for the deficiency cited at F250, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$2000.00 for the deficiency cited at F309, (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$5700.00 for the deficiency cited at F323, (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 26, 2016 be rescinded as of December 29, 2015. (42 CFR 488.417 (b))

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245513 _{Y1}	B. Wing	Y2	1/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF	BUFFALO	310 LAKE BOULEVARD		
		BUFFALO, MN 55313		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	M	DATE	ITEM		DATE	ITEM			DATE
Y4	1	Y5	Y4		Y5	Y4			Y5
ID Prefix	F0156	Correction	ID Prefix	F0157	Correction	ID Prefix	F0166		Correction
Reg. #	483.10(b)(5) - (10 483.10(b)(1)), Completed	Reg. #	483.10(b)(11)	 Completed	Reg.#	483.10(f)(2)		Completed
LSC		12/29/2015	LSC		12/29/2015 	LSC			12/29/2015
ID Prefix	F0167	Correction	ID Prefix	F0225	Correction	ID Prefix	F0226		Correction
Reg. #	483.10(g)(1)	Completed		483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg.#	483.13(c)		Completed
LSC		12/29/2015	LSC		12/29/2015 	LSC			12/29/2015
ID Prefix	F0241	Correction	ID Prefix	F0242	Correction	ID Prefix	F0244		Correction
Reg. #	483.15(a)	Completed	Reg. #	483.15(b)	Completed	Reg.#	483.15(c)(6)		Completed
LSC		12/29/2015	LSC		12/29/2015	LSC			12/29/2015
ID Prefix	F0250	Correction	ID Prefix	F0282	Correction	ID Prefix	F0285		Correction
Reg. #	483.15(g)(1)	Completed	Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.20(m), 483.20)(e)	Completed
LSC		12/29/2015	LSC			LSC			- 12/29/2015 -
ID Prefix	F0309	Correction	ID Prefix	F0312	Correction	ID Prefix	F0315		Correction
Reg. #	483.25	Completed	Reg. #	483.25(a)(3)	Completed	Reg.#	483.25(d)		Completed
LSC		12/29/2015	LSC			LSC			12/29/2015
REVIEWE STATE AG		REVIEWED BY (INITIALS) BF/KJ	DATE 01/28/20	SIGNATURE OF S		35575		DATE 01	/21/2016
REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE	<u> </u>			DATE	

POST-CERTIFICATION REVISIT REPORT

	R / SUPPLIER / CI ATION NUMBER		MULTIPLE CONSTA. Building B. Wing	TRUCTION							DATE 0	F REVISIT
NAME OF	FACILITY DGE CARE CEN	NTER OF	<u> </u>				310 LA	T ADDRESS, CIT KE BOULEVARD LO, MN 55313	Y, STATE, ZIF	Y2 CODE	11/21/20	10 Y3
program, corrected provision	to show those dand the date su	leficiencie ich correc	tive action was a	rted on the complished	CMS-25 d. Each	667, Staten deficiency	nent of D should I	eficiencies and be fully identifie	Plan of Cor d using eithe	ent Amendments rection, that have er the regulation o of each requirem	r LSC	
ITEN	И		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix	F0323		Correction	ID Prefix	F0333			Correction	ID Prefix	F0353		Correction
Reg.#	483.25(h)		Completed	Reg. #	483.25(m)(2)		Completed	Reg. #	483.30(a)		Completed
LSC			12/29/2015	LSC				12/29/2015	LSC			12/29/2015
ID Prefix	F0356		Correction	ID Prefix	F0371			Correction	ID Prefix	F0412		Correction
Reg.#	483.30(e)		Completed	Reg.#	483.35(i)		Completed	Reg.#	483.55(b)		Completed
LSC			12/29/2015	LSC				12/29/2015	LSC			12/29/2015
ID Prefix	F0428		Correction	ID Prefix	F0441			Correction	ID Prefix	F0490		Correction
Reg.#	483.60(c)		Completed	Reg. #	483.65			Completed	Reg. #	483.75		Completed
LSC			12/29/2015 -	LSC				12/29/2015	LSC			12/29/2015
ID Prefix	F0520		Correction									
Reg.#	483.75(o)(1)		Completed									
LSC			12/29/2015 									
REVIEWE		REVIEW		DATE		SIGNATUR	RE OF SU	IRVEYOR	<u> </u>		DATE	
STATE AG	ENCY	(INITIAL	BF/KJ	01/28/2	2016			35	575		01/	21/2016
REVIEWEI	D ВҮ	REVIEW (INITIAL		DATE		TITLE					DATE	
FOLLOWUP TO SURVEY COMPLETED ON [10/26/2015						D DEFICIENCIES CMS-2567) SEN			☐ YES	s 🔲 no		

POST-CERTIFICATION REVISIT REPORT

	R / SUPPLIE							DA	ATE OF REVISIT
245513	CATION NUM	IBEK	A. Building 01 - B. Wing	MAIN BUILDING 0	11			_{vo} 12	2/1/2015
	· FAOULITY		γ1			OTDEET ADDRESS OF	V 07475 710 0005	12	./1/2013 _{Y3}
	FACILITY	CEN	NTER OF BUFFALO			STREET ADDRESS, CIT 310 LAKE BOULEVARD	Y, STATE, ZIP CODE	<u>-</u>	
LAKE KI	DGE CARE	CEI	NIER OF BUFFALO			BUFFALO, MN 55313			
						120.17.20,			
program, corrected provision	to show the	ose o ite si d the	by a qualified State surveyor deficiencies previously report uch corrective action was a de identification prefix code p	orted on the CMS-29 ccomplished. Each	567, Stater deficiency	ment of Deficiencies and should be fully identifie	Plan of Correction d using either the r	n, that have bee regulation or LS	SC .
ITE	M		DATE	ITEM		DATE	ITEM	,	DATE
Y4			Y5	Y4		Y5	Y4		Y5
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#	NFPA 101		Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0056		12/01/2015	LSC			LSC		
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #			Completed	Reg. #		Completed	Reg. #		Completed
LSC				LSC			LSC		
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#			Completed	Reg. #		Completed	Reg. #		Completed
LSC				LSC			LSC		
ID Profix			Correction	ID Prefix		Correction	ID Prefix		Correction
ID Prefix			Correction	ID FIEIX		Correction	ID FIEIX		Correction
Reg. #			Completed	Reg. #		Completed	Reg. #		Completed
LSC				LSC			LSC		
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #			Completed	Reg. #		Completed	Reg. #		Completed
LSC				LSC			LSC		<u> </u>
REVIEWE	D BY		REVIEWED BY	DATE	SIGNATUI	RE OF SURVEYOR	<u> </u>	DA	JTE
STATE AC	SENCY		(INITIALS) TL/KJ	01/28/2016		3476	54		12/01/2015
REVIEWE CMS RO	D BY		REVIEWED BY (INITIALS)	DATE	TITLE			DA	
	FOLLOWUP TO SURVEY COMPLETED ON 10/22/2015				PRRECTED DEFICIENCIES SENCIES (CMS-2567) SEN			YES NO	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered January 28, 2016

Mr. Jason Nelson, Administrator Lake Ridge Care Center of Buffalo 310 Lake Boulevard Buffalo, Minnesota 55313

Re: Reinspection Results - Project Number S5513025 & H5513019

Dear Mr. Nelson:

On January 21, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 26, 2015, that included an investigation of complaint number H5513019, with orders received by you on November 19, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	Γ
IDENTIFICATION NUMBER	A. Building			
00714 _{Y1}	B. Wing	Y2	1/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF	BUFFALO	310 LAKE BOULEVARD		
		BUFFALO, MN 55313		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20130		Correction	ID Prefix	20255		Correction	ID Prefix	20265		Correction
Reg.#	MN Rule 4658.00 Subp. 1	50	Completed	Reg. #	MN Rul	e 4658.0070	Completed	Reg. #	MN Rule 4658.008	35	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	20565		Correction	ID Prefix	20800		Correction	ID Prefix	20830		Correction
Reg.#	MN Rule 4658.04 Subp. 3	05	Completed	Reg. #	MN Rul Subp. 1	e 4658.0510	Completed	Reg. #	MN Rule 4658.052 Subp. 1	20	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	20840		Correction	ID Prefix	20860		Correction	ID Prefix	20910		Correction
Reg.#	MN Rule 4658.05 Subp. 2 B	20	Completed	Reg. #	MN Rul Subp. 2	e 4658.0520 ? F.	Completed	Reg. #	MN Rule 4658.052 Subp. 5 A.B	25	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	21330		Correction	ID Prefix	21375		Correction	ID Prefix	21426		Correction
Reg.#	MN Rule 4658.07 Subp. 2 A&B	25	Completed	Reg. #	MN Rul Subp. 1	e 4658.0800	Completed	Reg.#	MN St. Statute 144 Subd. 3	4A.04	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
ID Prefix	21475		Correction	ID Prefix	21530		Correction	ID Prefix	21545		Correction
Reg.#	MN Rule 4658.10 Subp. 1	05	Completed	Reg. #	MN Rul A.B.C	e 4658.1310	Completed	Reg. #	MN Rule 4658.132 A.B.C	20	Completed
LSC			12/29/2015	LSC			12/29/2015	LSC			12/29/2015
REVIEWE		REVIEWE		DATE		SIGNATURE OF	SURVEYOR			DATE	
STATE AC	GENCY 💟	(INITIALS	BF/KJ	01/28/	2016		3557	5		01/2	1/2016
REVIEWE CMS RO	ED BY	REVIEWS (INITIALS		DATE		TITLE				DATE	

Page 1 of 2 EVENT ID: 28WI12

STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION DATE OF REVISIT PROVIDER / SUPPLIER / CLIA / **IDENTIFICATION NUMBER** A. Building B. Wing 1/21/2016 00714 Y3 NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y4 Y5 Y5 Y4 Y4 Y5 Correction ID Prefix 21665 Correction **ID Prefix** 21800 Correction **ID Prefix** 21805 MN Rule 4658.1400 MN St. Statute144.651 MN St. Statute 144.651 Reg. # Completed Completed Reg. # Reg. # Completed Subd. 4 Subd. 5 12/29/2015 12/29/2015 12/29/2015 LSC LSC LSC **ID Prefix ID Prefix** 21830 Correction **ID Prefix** 21870 Correction 21880 Correction MN St. Statute 144.651 MN St. Statute 144.651 MN St. Statute 144.651 Reg. # Reg. # Completed Reg. # Completed Completed Subd. 10 Subd. 18 Subd. 20 12/29/2015 12/29/2015 12/29/2015 LSC LSC LSC **ID Prefix** 21980 Correction MN St. Statute 626.557 Reg. # Completed Subd. 3 12/29/2015 LSC **REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE REVIEWED BY STATE AGENCY (INITIALS) BF/KI 01/28/2016 35575 01/21/2016 TITLE DATE **REVIEWED BY REVIEWED BY** DATE CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 10/26/2015 ☐ YES □ NO

Page 2 of 2 EVENT ID: 28WI12

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 28WI

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY 1	THE STAT	E SURVEY AG	GENCY	Fa	acility ID: 00714
MEDICARE/MEDICAID PROVIDER N (L1) 245513	10.	3. NAME AND ADD	E CARE CENT		FALO		4. TYPE OF ACTION: 1. Initial	2 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 066663700		(L4) 310 LAKE B (L5) BUFFALO, N			(L6)	55313	3. Termination 5. Validation 7. On-Site Visit	 CHOW Complaint Other
5. EFFECTIVE DATE CHANGE OF OW (L9) 02/01/2004	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR 05 HHA	RY 09 ESRD	<u>02</u> (L7) 13 PTIP) 22 CLIA	8. Full Survey After Con	
6. DATE OF SURVEY 10/26 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING I	DATE: (L35)
2 AOA 3 Other		04 311	00 01 1/31	12 KHC	10 HOSTICE		1,010	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY		:				
From (a): To (b):		X A. In Complian Program Re Compliance	equirements			nnical Personnel	6. Scope of Servic 7. Medical Directo	
12.Total Facility Beds	56 (L18)		Acceptable POC			ay RN (Rural SNF) Safety Code	8. Patient Room Si 9. Beds/Room	ize
13.Total Certified Beds	56 (L17)		pliance with Program ents and/or Applied		* Code:	A1*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY M	EETS		
18 SNF 18/19 SNF 56	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	SS (IF APPLICABLE S	SHOW LTC CANCELL	LATION DATE):	'				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY AP	PROVAL	Date:
Mary Rogers, HPR Soc	ial Work Spe	<u>ecialis</u> t	12/10/2015	(L19)	Kate Jo	<u>hnsTon, P</u>	rogram Specialis	12/14/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	SINGLE STAT	TE AGENCY	
19. DETERMINATION OF ELIGIBILITY X. 1. Facility is Eligible to Par			MPLIANCE WITH O	CIVIL	2. 0		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-	-1513)
2. Facility is not Eligible								
	(L21)				ı			
22. ORIGINAL DATE	23. LTC AGREEM		24. LTC AGREEM		26. TERMINAT		`	.30)
OF PARTICIPATION 02/01/1988	BEGINNING	DATE	ENDING DAT	ΓE	01-Merger, Closu	00 ure n W/ Reimbursemen	05-Fail to Me	et Health/Safety
(L24)	(L41)	E GANCTIONG	(L25)		03-Risk of Involu			et Agreement
25. LTC EXTENSION DATE:	A. Suspension		(L44)		04-Other Reason	for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	(2)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
	T-00	03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION (OF APPROVAL DA		Posted 12	/14/2015 Co.		
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL	



Electronically delivered November 19, 2015

Mr. Jason Nelson, Administrator Lake Ridge Care Center Of Buffalo 310 Lake Boulevard Buffalo, Minnesota 55313

RE: Project Number S5513025, H5513019

Dear Mr. Nelson:

On October 26, 2015, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 26, 2015 extended survey, investigation of complaint number H5513019 was conducted.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ)** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the October 26, 2015 extended survey the Minnesota Department of Health completed an investigation of complaint number H5513019 that was found to be substantiated at F323.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on October 23, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Brenda.fischer@state.mn.us

Phone: (320) 223-7338 Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective November 24, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F250 (S/S=G), effective October 26, 2015 (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F309 (S/S=G), effective October 26, 2015 (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323 (S/S=J), effective October 26, 2015 (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lake Ridge Care Center Of Buffalo is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 26, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 26, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 26, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 12/10/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/3	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAKE BOULEVARD UFFALO, MN 55313	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	Department of Hea through October 26 an Immediate Jeop facility's failed responding second degree spilled onto his left the high potential for administrator and donotified of the immediate	ucted by the Minnesota Ith on October 19, 2015, 5, 2015. The survey resulted in ardy (IJ) at F323 related to the onse after a resident obtained be burns from hot coffee that foot/ankle, which resulted in or harm or death. The facility director of nursing (DON) were rediate jeopardy on 10/21/15, at	F O	000			
	4:50 p.m. after the degree burns from on October 23, 201 In addition a comple completed for H551 which resulted in a The facility's plan or as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated.	aint investigation was 13019, and was substantiated deficiency at F353. If correction (POC) will serve of compliance upon the potance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will					
F 156 SS=D	validate that substaregulations has been your verification. 483.10(b)(5) - (10), RIGHTS, RULES, Some the facility must inform and in writing in a later than the facility must inform the facility m	ur facility may be conducted to initial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident	F 1	56	TITLE		12/29/15 (X6) DATE

Electronically Signed 11/27/2015

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245513	B. WING		10.	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 156	regulations governi responsibilities duri facility must also princtice (if any) of the §1919(e)(6) of the Amade prior to or up resident's stay. Re any amendments to writing. The facility must infentitled to Medicaid of admission to the resident becomes exitems and services facility services und which the resident other items and services facility services under the amount of charginform each resident to the amount of charginform each resident (i)(A) and (B) of this The facility must infat the time of admist the resident's stay, facility and of chargincluding any chargunder Medicare or the facility must full legal rights which in A description of the funds, under paraginal materials.	or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the estate developed under Act. Such notification must be on admission and during the ceipt of such information, and of it, must be acknowledged in form each resident who is a benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing fler the State plan and for may not be charged; those exices that the facility offers esident may be charged, and ges for those services; and and when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or esion, and periodically during of services available in the less for those services, ees for services not covered by the facility's per diem rate.	F 1	56		

AND DUAN OF CORDECTION TO THE TOTAL NUMBER.		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10	10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP O 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 156	for establishing eligithe right to request 1924(c) which deternon-exempt resour institutionalization as spouse an equitable cannot be consider toward the cost of medical care in his down to Medicaid exemples of all perting groups such as the agency, the State is ombudsman prograd vocacy network, unit; and a stateme complaint with the agency concerning misappropriation of facility, and non-codirectives requirem. The facility must imname, specialty, arphysician responsible. The facility must provide the facil	pibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment the institutionalized spouse's or her process of spending eligibility levels. It, addresses, and telephone inent State client advocacy State survey and certification censure office, the State am, the protection and and the Medicaid fraud control and that the resident may file a State survey and certification resident abuse, neglect, and it resident property in the mpliance with the advance	F 15				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	10/-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156	This REQUIREME by: Based on interview facility failed to enswere provided the non-coverage upon services. Findings include: A facility Admission Report dated 4/15/was admitted with "Medicare Part A," 32 days. R98's medical reconformation was idented the required notice prior to her Medicare During interview of worker (SW)-A state vidence R98 was Provider Non-Coveradmitted for a them should have been days before her conformation up in p.m., SW-A stated policy on ensuring	age 3 INT is not met as evidenced w and document review, the sure 1 of 3 residents (R98) required notice of Medicare in termination of the covered In/Leave/Discharge Tracking In/Leave/Discharge T	F 156	F156-D Facility timely submits this response plan of correction pursuant to fedes state law requirements. This respond plan of correction are not admor an agreement that a deficiency exist or that a statement of a defice was correctly cited or factually base it's not to be construed as an admagainst interest of the facility, the administrator, of any employees, a or other individuals who participate drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care to insure residents are provided the required notice of Medicare non-ocupon termination of the covered set. To assure continued compliance, if following plan has been put into plants. Resident is no longer on Medicare coverage. 2. Actions taken to identify other poresidents having similar occurrence residents having similar occurrence Reviewed all residents involved with Medicare back to the exit of the suensure other residents that could potentially have been affected were identified. 3. Measures put in place to ensure deficient practice does not recur:	eral and onse nissions does iency eed and ission agents ed in the or Center e overage ervices. The ace; cotential es: the arvey to be e	

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 156	consult with the res known, notify the re or an interested fan accident involving t injury and has the p intervention; a signi physical, mental, or	IFY OF CHANGES	F 1	Education was completed on 2 Now with Social Workers and MDS Coor to address the change in process for completing Medicare Denials using Medicare guidelines as the resource Social Worker will be notified at bi-widelicare Meeting of upcoming deniand administer denials timely, follow scanning into the medical record. 4. Effective implementation of action be monitored by: MDS Coordinator will perform week audits to insure Medicare denials have been issued timely and scanned intresident medical record. Findings were ported to the Quality Assurance meetings for the next two quarters. 5. Those responsible to maintain compliance will be: The Social Worker will be responsible compliance. Completion date for certification put only is: 29 Dec 2015	rdinator or CMS e. weekly itals wed by the will be to the will be to the rposes	12/29/15

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245513		B. WING		10/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	;	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	,	0, = 0.10	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 157	clinical complication significantly (i.e., and existing form of tree consequences, or a treatment); or a detect the resident from the \$483.12(a). The facility must all and, if known, the representation or interested family change in room or specified in \$483.1 resident rights under the resident rights resident rights under the resident rights.	threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge ne facility as specified in so promptly notify the resident resident's legal representative member when there is a roommate assignment as 15(e)(2); or a change in the rederal or State law or cified in paragraph (b)(1) of	F 157	7			
	the address and phelegal representative. This REQUIREMED by: Based on observative review, the facility foctor in a timely facility facility foctor in a timely facility foctor in a timely facility facility facility foctor in a timely facility fac	cord and periodically update none number of the resident's e or interested family member. NT is not met as evidenced tion, interview and document ailed to update the medical ashion for 1 of 1 residents sed concerns of unmanaged ident (R45) who developed low ring treatment. Minimum Data Set (MDS) atified R118 had no cognitive ed assistance to complete aily living (ADLs), did not pain medications, however,		F157-D Facility timely submits this response plan of correction pursuant to fedestate law requirements. This response and plan of correction are not admoran agreement that a deficiency exist or that a statement of a deficiency of the factually base it is not to be construed as an admit against interest of the facility, the administrator, of any employees, a or other individuals who participate drafting or who may be discussed otherwise identified the same.	ral and onse issions does ency ed and ssion gents d in the		

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	10/26/2015	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	non-pharmacologi pain. The MDS als difficult to sleep at day activity, was fr venous ulcer. R118's pain Care 8/24/15, identified right leg that was i large amounts of findicated, "Staff w and update MD [m During observation 11:30 a.m. R118 w and applying an ic complained of unropen sore to her migust had a routine the area, and the pichanges, "Hits ovenumeric pain ratin most intense pain was treated with piche dressing change think of it." On 10/22/15, at 9: her room, receiving from licensed pract LPN-F and R118 of a pain medication to treat liked to wait "for hed dressing change with the complex of the dressing change of the dressin	age 6 ad (PRN) pain medication and cal interventions to manage so identified the pain made it night, and limited her day to requent, and one arterial or Area Assessment (CAA) dated R118 had a stasis ulcer on her nfected and continued to drain luid. The assessment ill continue to monitor for pain nedical doctor] as needed." In and interview on 10/21/15, at was rubbing her right lower leg, e pack to the same area. R118 managed pain related to an ight, lower leg stating she had dressing change completed to pain during these dressing er a 10" on a zero (0) to 10, g scale (0 = no pain, 10 = the imaginable). R118 stated she ain medication prior to having ged only, "If we [staff and her] 28 a.m. R118 was observed in g her morning medications ctical nurse (LPN)-F. Both confirmed she had just received (Gabapentin 300 mg, pain to nerve pain) and she typically er pain pill to kick in," before her was completed. R118 asked a half hour to complete her and to bring an ice pack. At stated, "[Her pain medication]	F 1	It is the policy of Lake Ridge to update the medical doct fashion. To assure continued comp following plan has been pure 1. Regarding cited resident Resident 118's medical recommanagement was reviewed Medical providers contacted since survey for review and pain management. Resident 45's insulin/blood were reviewed and the mewas updated multiple times 15 to obtain orders for blood parameter notification if synce 2. Actions taken to identify residents having similar on All residents have the pote Residents with uncontroller reviewed to ensure the phyaware of any changes and with the changes related to the Resident's with diagnosis of have the potential for blood outside of parameters. Resugars were reviewed for pensure the physician was a changes and was updated changes if needed. 3. Measures put in place to deficient practice does not	liance, the at into place; ts: cord for pain d on 28 Oct 15. ed several times d adjustment of discal provider is since 30 Oct od sugar imptomatic. other potential courrences: intial for pain. d pain were a visician was was updated or pain. of diabetes d sugars issident's blood oast month to aware of with the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/10/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						MB NO. 0938-039 I	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE RII	DGE CARE CENTER	OF BUFFALO			IO LAKE BOULEVARD		
				ь	UFFALO, MN 55313	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	there's nothing [tha 10:11 a.m., LPN-F dressing change. Wroom, R118 was as medications were hoos," and rated he pain scale. At 10:16 R118's resident roopreparations for the about to begin the t"Where's my ice paforgotten to bring thimmediately upon change. R118 said that now." LPN-F saretrieved an ice paddressing change. At the Kerlix (gauze bahighly absorbent dreadding and protect then used a saline apieces of Silversorb slough, by wiping, recolored debris from LPN-F was removing completing debridm wincing, jerking and procedure. At 10:27 eyes, which she with held in her hand the During the dressing stop and pause seven and breathe before ready for LPN-F to change she would the face, and choked the state of th	when they start scraping, to could stop the pain]." At gathered supplies for R118's While LPN-F was outside of the ked whether her pain elping. She stated, "[It] never pain a seven, out of 0-10 a.m. LPN-F returned to m, completed her dressing change and was reatment when R118 asked, ck?" LPN-F stated she had be ice pack, but would bring it completion of the dressing loudly and firmly, "No. You get aid, "Okay, yes mam." LPN-F ck and then began the to 10:22 a.m., LPN-F removed andage rolls) and ABD pad (a essing used to provide tion for large wounds). LPN-F aerosol spray to slowly remove of (an absorptive dressing) and olling and picking off the black R118's open wound. While	F 1	57	Education on notification to medical provider with condition change, dial blood sugar management and pain management was completed by 13 15 for licensed nurses and TMAs. Morning IDT stand up meetings implemented on 30 Dec 15 to monichange in conditions and MD notifice 4. Effective implementation of action be monitored by: Will audit ten residents with change condition related to blood sugars and with wound treatment to ensure me provider was updated and will also ten MARs/TARs monthly for three refor pain effectiveness and blood sugurside parameters to ensure mediprovider was updated. Facility will complete five audits of residents using the modified CMS of Resident Interview Observation or modified CMS QIS Non-Interviewal Resident Observations weekly for the months. The data collected will be presented to the Quality Assessment & Assection Committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing is responsicompliance.	betic/ Dec tor for cation. In swill es in addical audit months gars cal QIS Die hree In that wrance grany to be	
	her face, and choke voice, and said "oka	ed with emotional tone to her			The Director of Nursing is responsi	ble for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)		BE	(X5) COMPLETION DATE
F 157	medication to beg I'm just gonna have the pain." As soon R118 immediately right lower leg and stockinet and grip allowing R118 to be dressing change with time to admin medication (oxycopain medication) to the medication, as gripper stocks, an R118 rated her paddressing change, because I'm about pain." At 10:43 a.r pack, firmly to her her pain as an eig was starting to de ask R118 to rate in the dressing change was starting to de ask R118 to rate in the dressing change was starting to de ask R118 to rate in the dressing change change in indicators du typical for her. LF nurse practitioner R118's pain mana offering Ultram (at then oxycodone (at Ultram was not ef resident could als relieve the pain. It of any changes in	ot left enough time for her pain in working. R118 replied, "No, re to get something stronger for as LPN-F applied the Kerlix, applied the ice pack to her made LPN-F stop before the per socks were applied, breathe, and rest after the vas completed. LPN-F used ister another PRN pain addone 5mg 1 tablet, narcotic of R118. LPN-F administered applied R118's stockinet and dat 10:37 a.m., left the room. In as a nine, and during the stated, "It's gotta hit 15, to ready to pass out from the m., R118 was still holding the ice leg. At 10:45 a.m., R118 rated the holding at this time. LPN-F did not her pain before, during or after ge even though LPN-F and pain medication to R118. In 10/22/15, at 10:51 a.m. In had verbal and non-verbal ring the dressing change, was and the dressing change, was and the pain medication) first, an arcotic pain medication) if the fective. LPN-F stated the pain medication, and yone had discussed a change		157	Completion date for certification pur only is: 29 Dec 15	poses	

(X3) DATE SURVEY COMPLETED		
/26/2015		
(X5) COMPLETION DATE		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED		
		245513 B. WING		-	10/26/2015			
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STAT 310 LAKE BOULEVARD BUFFALO, MN 55313	TE, ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE	
F 157	and pain managem ·Wound treatment is lower extremity- cle dressing daily and is ·Gabapentin 300 m peripheral neuropa ·Ultram 50 mg, ever chronic pain syndre ·Oxycodone 5 mg, not relieved by Ultra Review of R118's E Administration Rec 10/25/15, identified medications were a extremity and leg p The September 20 a total of 103 doses She took 68 doses effective 42 of 68 o 14 of 68; not effecti was not identified for R118 had 35 doses September 2015, w 35 opportunities; sl other which was no opportunities. The October 2015 administered 100 dright, lower extremi doses of Ultram 50 of 49 opportunities; and not effective 6	the following wound treatment tent regimen: to stasis ulceration on right teanse wound, and change PRN. iilligrams (mg), twice daily for thy/ polyneuropathy. Try four hours PRN for pain, for ome. every four hours PRN for pain am, for chronic pain syndrome. Electronic Medication ord (EMAR) from 9/1/15, to the following as PRN pain administered for right, lower	F 1	57				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONS NG	COMPLETED				
		245513 B. WING				10/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310 LAK	ADDRESS, CITY, STATE, ZIP CODE E BOULEVARD LO, MN 55313			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 157	October 2015 which opportunities; slight effective 5 out of 5 identified, 1 out of 5 identified, 2	n was effective 34 out of 51 lly effective 11 out of 51; not and other, which was not	F 1	57				
	9/6/15 through 10/1 potential indicators On 9/7/15, at 1:39 potential indicators On 9/7/15, at 1:39 potential it would st leaving it open to a On 9/8/15, 11:10 p. pain to RLE. [R118 prn pain medication call physician sain Tylenol. Will admin monitor." On 9/19/15, at 1:12 c/o 7/10 pain right I relieved with prn tradressing changed & On 9/23/15, 10:39 potential medicated as directions.	ursing progress notes from 7/15, included the following of poor pain control: o.m. registered nurse (RN)-C sed to have dressing put on in art hurting again [R118] is ir. PRN given." m. LPN-C noted, "[R118] c/o is unable to have any more of for another 2 [two] hours. On the dister Tylenol and continue to a.m. LPN-D noted, "[R118] ower extremity; somewhat amadol, ice, and oxycodone; by DON [director of nursing]." o.m. LPN-I noted, "[R118 was] ted for leg pain. [R118] states, en drainage is left on my leg."						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245513	B. WING _			10/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD E	3E	(X5) COMPLETION DATE	
F 157	continues to c/o parchanges et PRN pain 7/10 pack and PRN pain During interview on registered nurse (Rephysician was at the was responsible pain management reffective. When ask that R118's physician/ nurse proon her pain in physician/ nurses or Nastaff would have up they identified unmachanges to her pain R45's annual MDS was cognitively intareceived insulin dai. Lake Ridge Care Control Report dated 4/20/subcutaneous once	p.m. LPN-F noted, "[R118] n et request frequent dressing in meds which were helpful RN pain meds were given 37 p.m. LPN-D noted, "[R118] n, somewhat relieved with ice medication." 10/26/15, at 2:32 p.m. N)-H reported R118's efacility every Thursday and for monitoring to ensure her regimen was sufficiently ked when the last time was an was updated on and/or pain management, RN-H recent notation of the actitioner having commented cian progress notes, was oned that she was aware R118 with dressing changes, but the pain management regimen r. RN-H denied any reports of concerns for R118, from the As and would expected her dated the physician if/when anaged pain, to makes a regime. dated 8/11/15, indicated she ct, had diabetes mellitus and ly. enter signed Physician Order 15, indicated Lantus 37 units	F 1	57				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	units at bedtime. R45's Diabetic Adm 4/30/15, indicated I morning with a star HS (at bed time), w Diabetic Administra R45 received Lanta to 4/26/15. The Buffalo Clinic 1 4/8/15, indicated at Lake Ridge care ce today, and told per Per the Buffalo Cliri dated 4/27/15, Dr. A p.m., "Discussed w 4/20/15 visit, had w units at bedtime wh daily MORNING Do patient has been re daily since the last sugars." Dr. Anders units once daily in t stay. Lake Ridge Care C on 4/22/15, at 7:44 only 52 mg/dl (millig the medical record was notified of the Resident Progress a blood sugar was her breakfast meal	ninistration History 4/1/15, to Lantus 37 units once in the date of 4/17/15 and Lantus at with a start date of 4/20/15. The lation History report indicated us 37 units at HS from 4/20/15. Telephone order report dated as:58 a.m. received call from enter, had blood sugar of 67 orders to call if below 80. Thic Telephone order report Anderson indicated at 5:34 with (staff) by phone. As of written to return to Lantus 37 then it should have been once DSE> Clarified with (staff) exceiving lantus 37 units twice visit with recent low blood son then ordered Lantus 37 the morning as prior to hospital denter Vitals Report identified a.m. R45 blood glucose was grams per deciliter). Review of did not indicate the physician	F 15	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245513		B. WING			10/26/2015	
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO				310 L	ET ADDRESS, CITY, STATE, ZIP CODE AKE BOULEVARD FALO, MN 55313	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page 14 Resident Progress Note dated 4/26/15, at 3:30 a.m. blood sugar of 51. Review of the medical record did not indicate the physician was notified of the low blood glucose. Resident Progress Note dated 4/27/15, at 8:33 a.m. indicated "Resident had low BS (blood sugar) this morning was sweating and shaky. she had a BS of 38. The physician was called at 8:44 a.m." Resident Progress Note dated 4/27/15, at 5:37 p.m. indicated "Resident had been receiving Lantus 37 units BID (twice a day) since 4/20, miscommunication written upon return from appointment. Spoke with Dr. Anderson and the HS dose has been d/c'd (discontinued) and will continue the 37 units in AM." During interview 10/26/15, at 9:30 a.m. with the DON who stated she was not aware of the insulin discrepancy and stated she was unable to locate a medication error. The DON further stated the nurses should have called the physician when they noted the order for Lantus to be given at HS since she was not on that before and because of her low blood sugars. Although R45 had an order to notify the physician if blood sugars were below 80, the facility did not		F 1	57	DEFICIENCY)		
	The facility's Chang Status policy dated the policy of Elim C resident, his or her representatives of o	of the three low blood sugars. ge in Resident's Condition Or 7/14, directed "POLICY: It is are, Inc. to promptly notify the Attending Physician, and changes in the resident's addition and/or status."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 110 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 166 SS=D	A resident has the facility to resolve ghave, including the of other residents. This REQUIREMED Based on interview facility failed to attegrievance for 1 of expressed concernbruising. Findings include: R45's annual Minimal Mini	right to prompt efforts by the rievances the resident may se with respect to the behavior. ENT is not met as evidenced w and document review, the empt to resolve an individual 1 residents (R45) who had no over lift placement and. mum Data Set (MDS) dated R45 was cognitively intact and e of two staff for transfers. El Action Form dated 8/12/15, "had complaints that when she to a nurse she feels they do asly Had concerns about lift not and bruising [R45] felt she usly." The action form wen to the DON. The form tor of nursing (DON) response: ling well and gets and with illness. this writer did that she down played the	F 166	F166-D Facility timely submits this response plan of correction pursuant to federal state law requirements. This response and plan of correction are not admiss or an agreement that a deficiency do exist or that a statement of a deficient was correctly cited or factually based it's not to be construed as an admiss against interest of the facility, the administrator, of any employees, age or other individuals who participated drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Cetto resolve expressed grievances prompted by residents. To assure continued compliance, the following plan has been put into place 1. Regarding cited residents: Weekly skin check completed on Resident 45 on 28 Oct 15 with no fur bruises noted. Interviewed Resident on 23 Nov 15 to ensure transfers were constraint according to resident	and se sions es cy and ion ents in the enter 45	
		a big deal. The DON stated it but never investigated if there		occurring according to resident preferences. Transfer observation w	rith	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 166	Continued From pa	ge 16	F 1	F 166			
	was bruising or how the staff were transferring the resident. The DON had not implemented any actions in effort to resolve R45's concern with the lift.				Resident 45 will be completed periodica as facility does mechanical lift transfer audits.		
	During interview on R45 stated the staff when she made a comonths ago when sher ceiling lift, the sourcetly and it slid causing a skin tear "irritated" because s	10/23/15, at 12:23 p.m. with f did not always listen to her concern. R45 stated a few the was being transferred from trap was not connected down on her right arm, and bruising. R45 was she "made a grievance in ut didn't "think anything was			2.Actions taken to identify other poresidents having similar occurrence. The facility Vulnerable Adult log an Resident Council minutes from Ocwere reviewed by Administrator. Interviewable residents will be interplay for potential VA concerns and non-interviewable resident's weekly checks will be viewed to determine injuries of unknown origin and folloneeded by 13 Dec 15.	es: d tober viewed y skin	
	A facility Grievances and Complaints policy dated 1/12/12, indicated, "It is the policy of Lake Ridge Care Center to provide and environment that enhances resident dignity, security, comfort and peace of mind by allowing residents and staff the opportunity to voice their concerns to improve our facility." Further, the policy indicated, "If a resident, their representative, family member or advocate has a concern with any aspect of care, treatment, property or the facility; they are encouraged to bring that concern to the attention of the appropriate department manager."				3.Measures put in place to ensure deficient practice does not recur: Grievance and Complaints policy a form was reviewed and revised by 15. Staff education on handling regrievances and concerns and nurs staff education on transfer technique mechanical lift will be completed on Dec 15. Administrator will review Resident Council minutes after Recouncil meetings beginning in Nov 2015. 4.Effective implementation of action be monitored by: Facility will complete five audits of residents using the modified CMS Resident Interview Observation or modified CMS QIS Non-Interviewa Resident Observations weekly for three months. Facility will complete five Care Observations weekly for three months. Audits will be completed of	30 Oct sident ing ues with n 13 sident rember ns will QIS ble three NAR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	A resident has the rather most recent sur Federal or State sur correction in effect. The facility must mexamination and mexamination and mexamination.	T TO SURVEY RESULTS -	F 1		grievance log and Resident Council minutes monthly for three months. data collected on these audits will be presented to the Quality Assessmer Assurance Committee quarterly. At time the QA&A committee will make decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Administrator is responsible for compliance. Completion date for certification pur only is: 29 Dec 15	The he he that he the he h	12/29/15
	by: Based on observa documentation revi the most recent Sta	NT is not met as evidenced tion, interview and ew, the facility failed to ensure ate survey results were readily nt and family review. This had			F167-C Facility timely submits this response plan of correction pursuant to federa state law requirements. This response	al and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		-0,-010
I AKF RI	DGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD		
	DGE OAKE GERTER	01 D011A20		В	UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167	Continued From pa	ge 18	F 1	67			
	the potential to affect all 48 residents, visitors and staff who wished to review the information. Findings include: During the initial tour of the facility on 10/19/15, at 6:42 p.m. a clear plastic holder was attached to the wall by the entry way which contained a white three ring binder. The binder contained State survey results dated 10/24/13 (two years prior).				and plan of correction are not admi or an agreement that a deficiency of exist or that a statement of a defici- was correctly cited or factually base	does ency	
					was correctly cited or factually based and it's not to be construed as an admission against interest of the facility, the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same.		
	administrator stated worker (LSW)-A we	on 10/26/15, at 5:30 p.m. the d he or the licensed social ere responsible to update the 14 survey should have been			It is the policy of Lake Ridge Care to post survey results so that they a available for residents and families review.	are	
					To assure continued compliance, the following plan has been put into plant in		
					Regarding cited residents: The most recent survey results we posted on 26 Oct 15.	re	
					2.Actions taken to identify other poresidents having similar occurrence. All residents had potential to be afformatically by alleged deficient practice.	es:	
					3.Measures put in place to ensure deficient practice does not recur: Staff education addressing CMS requirements for posting of most resurvey results was completed by 15. Survey book will be updated work new survey result by Administrator are available.	3 Dec vith	
					4.Effective implementation of action be monitored by:	ns will	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER (OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 SS=D	been found guilty of mistreating resident had a finding entereregistry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit. The facility must en involving mistreatments.	(c)(2) - (4) PORT DIVIDUALS It employ individuals who have abusing, neglecting, or as by a court of law; or have ad into the State nurse aide abuse, neglect, mistreatment appropriation of their property; which would be a memployee, which would be service as a nurse aide or the State nurse aide registry	F 1		Facility receptionist will verify correct survey results are posted on a week basis and will complete the audit too three months. The results collected be presented to the next Quality Assessment & Assurance Committed quarterly meeting. At that time, the committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Administrator will be responsible compliance. Completion date for certification pure only is: 29 Dec 15	kly ol for d will ee QA&A g any to be	12/29/15
	involving mistreatme	ent, neglect, or abuse,					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE	
F 225	immediately to the to other officials in through established State survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and the facility must have a survey and investigation is in pure the facility of all in to the administrator of the facility of the fac	resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). Ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 22	5			
	by: Based on interview facility failed to ens neglect and injuries immediately reporte agency and thoroug residents (R45, R1 allegations were re Findings include: R45's annual Minin 8/11/15, indicated s required assist of the A Resident Council	NT is not met as evidenced and document review, the ure allegations of abuse, of unknown origin were ed to the administrator, state ghly investigated for 3 of 5 04 and R131) whose viewed. The Data Set (MDS) dated the was cognitively intact and wo staff with transfers. Action Form dated 8/12/15, 'had complaints that when she		F225-D Facility timely submits this responsible plan of correction pursuant to fedestate law requirements. This respond plan of correction are not admor an agreement that a deficiency exist or that a statement of a deficiency exist or that a statement of a deficiency exist or the astatement of a deficiency exist or the statement of a deficiency exist or the statement of a deficiency exist or the facility of the facility, the administrator, of any employees, and or other individuals who participate drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care	eral and onse nissions does iency sed and ission agents ed in the or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		 	10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER	3		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	R OF BUFFALO		E	BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	brings a complaint not take her seriou lift with sling place she wasn't taken s was given to the D	age 21 It to a nurse she feels they do usly" R45 had "concerns about ment and bruising," and, "felt seriously." The form identified it DON who responded, "Res feeling well and gets	F 2	225	to report allegations of abuse, neglication injuries of unknown origin immediate the administrator and state agency. To assure continued compliance, the following plan has been put into plan	tely to	
	paranoid/depresse her and that she dependent of nursing of R45's concern to the DON stated From the DON stated From the DON stated should be bruising on R45. During interview 1 stated the staff do she voices a concrough. R45 stated	deeling well and gets ed with illness did visit with own played the concern." 0/22/15, at 2:10 p.m. the (DON) stated she was aware out didn't feel it was of concern. A45's concern with the lift was including if there was bruising ere transferring the resident, at to the State agency. Further, he was was not aware of any 0/23/15, at 12:23 p.m. R45 n't always listen to her when ern that they (staff) can be a she was being assisted to oths prior, and the strap used by			1. Regarding cited residents: Incident for Resident 45 was submited 27 Nov 15 to OHFC. Investigation follow-up will be completed per regrompliance. Resident 131 and Resident 131 and Resident 131 and Residents having similar occurrence. The facility Vulnerable Adult log and Resident Council minutes from Octwere reviewed by Administrator. Interviewable residents will be interply for potential VA concerns and non-interviewable resident's weekly checks will be viewed to determine injuries of unknown origin and follows.	itted on and ulatory ident urvey. cential es: d ober viewed v skin	
	caused it to slide of bruising on her are "irritated" because out "owe, owe", but transfer. The staff despite her cries of Although R45 repo being rough causing there was no indice state agency were	not attached correctly which down and cause a skin tear and m. R45 stated she was a during the transfer, she yelled at the staff did not stop the f proceeded to transfer her, of pain, stating "it's OK." Orted during a transfer of staffing a skin tear and bruising ation the adminstrator and the immediately notifed, nor had been completed of the allegation.			needed by 13 Dec 15. 3.Measures put in place to ensure deficient practice does not recur: Facility Vulnerable Adult policy was reviewed and revised and educatio VAA abuse prohibition and reporting requirements was completed with and the facility guidelines for VAA reporting online was updated and education was completed with licer staff by 13 Dec 15. A revised griev and concern log was implemented Dec 15 to include "desired outcome Facility has implemented daily IDT	etaff staff ased ance on 28	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/20	15
	PROVIDER OR SUPPLIER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE B10 LAKE BOULEVARD BUFFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMP	X5) PLETION ATE
F 225	R104's admission he was cognitively An Incident report on 6/26/15 in R104 and overheard a mresident yelling and to hear what was a word "Fuck", and "tone of voice. Writ with nurse and saw (FM)-A was yelling asked if he wanted yes. FM-A was as writer before he counter the time was holding and was pointed to asked if his FM-A stated yes. Writer permission to do the Resident also stated been physically about threatened to kill home to try to ki	MDS dated 6/11/15, indicated intact and feels depressed. dated 6/29/15, indicated that It's room, "Writer got to the door ans loud voice that was not diswearing. Writer was unable all being said but did her the your and Asshole" in an angry er immediately went into room wresident's family member at resident. Resident was IFM-A to leave. Resident said ked to leave several times by implied with leaving. FM-A at angup his phone that had a light awards resident. Resident was vas video taping him. Resident asked residnet if FM-A had his and resident stated "no". FM-A had his in and resident stated "no". FM-A had his in and resident stated that FM-A had in into a bonfire at residents im, and he still had the scars ident express that he didn't FM-A back here at the facility the only one that has been ent also let writer know that is to his home, truck and was one back. FM-A told the nave to break into your house if yoing back there". Resident as his laptop and refusing to be investigation was submitted	F 225	up meetings starting 30 Oct 15 to refor potential vulnerable adult conced. 4. Effective implementation of action be monitored by: Facility will complete five audits of residents using the modified CMS Resident Interview Observation or modified CMS QIS Non-Interviewal Resident Observations weekly for the months. Facility will complete five Care Observations weekly for three months. Facility will complete five Education Audits of staff; audits will be completed on grievance log and Resident Council minutes monthly three months. Facility will monitor reports monthly for three months for timeliness of reporting to the Admir and state agency. The data collect these audits will be presented to the Quality Assessment & Assurance Committee quarterly. At that time to QA&A committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Administrator is responsible for compliance.	erns. Ins will QIS Is ble Insee NAR Is Abuse I also If for VAA Or Inistrator Is do not be Is any Is to be	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		245513	B. WING _	· · · · · · · · · · · · · · · · · · ·	10	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	immediately report had been reported. Although the incided facility did not report administrator and after the incident, R131's quarterly is she was moderate extensive assist on the lateral company of the incident on 4/3/15 R13 area to the lateral company of the incompany of the incident of the incid	the incident should have been ted and she did not know why it a late. ent occurred on 6/26/15, the ort the incident to the state agency until two days on 6/29/2015. MDS dated 2/25/15, indicated by cognitively intact and needed at two with transfers. eport dated 4/5/15, indicated at had a, "exp. large discolored left breast" which measured 10 y 8 cm in size. R131 was a rability to continue to be type of device, and R131 was uire a hoyer lift for transfers. and the state agency was cident on 4/5/15 two days later on was submitted to the state if, 10 days after the incident tified the injury was from a collection was sent late and didn't ent late "maybe it was a further, the DON stated e and the location, the incident	F 22	25		
	the state agency t	wo days later and the not reported until 10 days later.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
F 225	Policy and Procedulindicated "Each emususpected/alleged abuse/neglect immususpector of Nursing administrator will be the above. Staff mususpected and substimmediately to the agencies as required (common entry point (Minnesota Department further indicated "Aneglect and injuriest promptly and thorous ABUSE/NEGLECT. The facility must depolicies and procede mistreatment, negled and misappropriation. This REQUIREMED by: Based on interview facility failed to impus timely reporting and abuse, neglect, or interview facility failed, or interview	rable Adult Abuse Prohibition are revised November 2011, aployee is responsible to report violations of resident ediately to one of the supervisor, Nurse on Duty, or Social Worker. The enotified immediately by on of ay go immediately to the sired. Report all alleged tantiated incidents state agency and all other ed (oral report to CEP ent) and electronically to MDH ment of Health)." The policy Il reports of resident abuse, of unknown source shall be ughly investigated." PP/IMPLMENT, ETC POLICIES Evelop and implement written dures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced or and document review, the lement their policy for the dinvestigation of allegations of njuries of unknown origin for 3, R104, and R131) whose	F 2		al and onse ssions loes	12/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/	26/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		20/2013	
	IDGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	Findings include: A facility Vulnerable and Procedure revindicated, "Each erreport suspected/a abuse/neglect imm following: Nursing administrator will be the above. Staff mandministrator if desviolations and substimmediately to the agencies as require (common entry poing (Minnesota Depart further indicated "Aneglect and injuries promptly and thoromoly and thoromoly and thoromoly and the serious indicated that R45 brings a complaint not take her serious lift with sling placers she wasn't taken swas given to the Desire and that she do During interview 10 director of nursing	e Adult Abuse Prohibition Policy ised November 2011, imployee is responsible to lleged violations of resident rediately to one of the supervisor, Nurse on Duty, or Social Worker. The e notified immediately by on of ay go immediately to the sired. Report all alleged	F 22	was correctly cited or factuall it's not to be construed as an against interest of the facility administrator, of any employe or other individuals who parti drafting or who may be discurotherwise identified the same. It is the policy of Lake Ridge to develop and implement wround procedures that prohibit mistreatment, neglect and attresidents and misappropriation property. To assure continued compliate following plan has been put in the following plan has been put in the follow-up will be completed prompliance. Resident 45 was 27 Nov 15 to OHFC. Investign follow-up will be completed prompliance. Resident 131 ar 104 had VAA reports filed be 2. Actions taken to identify oth residents having similar occurs and the facility Vulnerable Adult In Resident Council minutes frowere reviewed by Administra Interviewable residents will be by for potential VA concerns non-interviewable residents will be viewed to determine of unknown origin an needed by 13 Dec 15. 3. Measures put in place to endeficient practice does not redeficient practice does not re	admission the ees, agents cipated in the ssed or e. Care Center itten policies ouse of on of resident once, the nto place; submitted on gation and er regulatory of Resident fore survey. her potential irrences: og and m October tor. e interviewed and weekly skin ermine d follow-up		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0, 0, 0
LAKE RI	DGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	The DON stated R never investigated or how the staff we nor was it reported the DON stated sh bruising on R45. During interview 10 stated the staff dor she voices a concerough. R45 stated transfer a few monthe ceiling lift was caused it to slide d bruising on her arm "irritated" because out "owe, owe", but ransfer. The staff despite her cries of Although R45 repobeing rough causing there was not invest adminstrator and the notified immediate. R104's admission he was cognitively. An Incident report on 6/26/15 in R104 and overheard a more resident yelling and to hear what was a word "Fuck", and "tone of voice. Writ with nurse and saw	45's concern with the lift was including if there was bruising are transferring the resident, to the State agency. Further, e was was not aware of any 0/23/15, at 12:23 p.m. R45 a't always listen to her when ern that they (staff) can be she was being assisted to this prior, and the strap used by not attached correctly which own and cause a skin tear and a. R45 stated she was during the transfer, she yelled at the staff did not stop the proceeded to transfer her, if pain, stating "it's OK." Tred during a transfer of staffing a skin tear and bruising stigation done and the state agency were not	F 2	226	Facility Vulnerable Adult policy was reviewed and revised and educatio VAA abuse prohibition and reporting requirements was completed with a and the facility guidelines for VAA reporting online was updated and education was completed with licer staff by 13 Dec 15. A revised griev and concern log was implemented Dec 15 to include "desired outcome Facility has implemented daily IDT up meetings starting 30 Oct 15 to nfor potential vulnerable adult concernation of actions be monitored by: Facility will complete five audits of residents using the modified CMS of Resident Interview Observation or modified CMS QIS Non-Interviewal Resident Observations weekly for the months. Facility will complete five of Care Observations weekly for three months. Facility will complete five of Questionnaire Audits of staff; audits completed on grievance log and Recouncil minutes monthly for three reacility will monitor VAA reports more for three months for timeliness of reporting to the Administrator and sagency. The data collected on the audits will be presented to the Quantassessment & Assurance Committed quarterly. At that time the QA&A committee will make the decision/recommendation regarding necessary follow-up audits needing continued.	n on g staff sed ance on 28 e". stand nonitor rns. ns will QIS ole hree NAR e Abuse s will be esident months. onthly state se lity ee g any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ITIEIOATIONI NII IMPER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/	26/2015
NAME OF I	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE	10/2	20/2013
LAKE RI	DGE CARE CENTER	OF BUFFALO			UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	asked if he wanted yes. FM-A was as writer before he counter that the time was holding and was pointed to asked if his FM-A stated yes. Writer permission to do the Resident also state been physically about threatened to kill home to try to kill home. Ractually pushed him home to try to kill home to try to kill home to try to kill home. Ractually pushed him home to try to kill home. Ractually pushed him home to try to kill home. Ractually pushed him home to try to kill home. Ractually pushed him home to try to kill home. Ractually pushed him home.	d FM-A to leave. Resident said ked to leave several times by implied with leaving. FM-A at ing up his phone that had a light owards resident. Resident was was video taping him. Resident asked residnet if FM-A had his his and resident stated "no". The determinant of the past, usive to him and has also im in the past while at esident stated that FM-A had in into a bonfire at residents him, and he still had the scars sident express that he didn't FM-A back here at the facility the only one that has been lent also let writer know that it is to his home, truck and was one back. FM-A told the have to break into your house if going back there". Resident has his laptop and refusing to be investigation was submitted by on 7/01/15. 10/26/15, at 6:13 p.m. with the ne incident should have been seed and she did not know why it late. 20/26/15, at 6:13 p.m. with the ne incident should have been seed and she did not know why it late. 20/26/15, indicated 2/25/15, indicated and Stated 2/25/15, indicated 2/25/1	F 2	26	5.Those responsible to maintain compliance will be: The Administrator is responsible fo compliance.	, and the second	
		ly cognitively intact and needed					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	extensive assist of An Investigative Re that on 4/3/15 R131 area to the lateral le cm (centimeter) by reassessed for her transferred in this ty determined to requi The administrator a informed of the inci and investigation wagency on 4/13/15, occurred and identimechanical lift. During interview 10 stated the investigation why it was se computer glich". Further the state agency two	two with transfers. port dated 4/5/15, indicated had a, "exp. large discolored of breast" which measured 10 8 cm in size. R131 was ability to continue to be to end of device, and R131 was re a hoyer lift for transfers. In the state agency was dent on 4/5/15 two days later as submitted to the state 10 days after the incident fied the injury was from a continue to be to the state the injury was from a continue to the state the injury was from a continue to the state the injury was from a continue the injury was a continue the injury	F 2.	26			
F 241 SS=D	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 2	41		12/29/15	
	manner and in an e enhances each res	omote care for residents in a nvironment that maintains or dent's dignity and respect in s or her individuality.					
	This REQUIREMEN	NT is not met as evidenced					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	6/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)) BE	(X5) COMPLETION DATE	
F 241	by: Based on observareview, the facility assistance with toi appropriate incontifor 1 of 2 residents concerns of undiginal Findings include: R126's admission dated 9/25/15, idea cognition, required toileting, and was a reded, and proposed for toileting, bathing to up to 30 minute answered, which consistency and helple for up to 30 minute answered, which consistency and act to complete post to provided bed pandottom that would left on the bed part himself down on not keep the linens	ation, interview and document failed to provide timely leting aftercares and ensure inence products were provided is (R126) who expressed nified care and services. Minimum Data Set (MDS) Intified R126 had intact extensive assistance for 'always' continent of bowel. Mated 10/12/15, identified staff continence products for R126 ovide assistance from one staff	F 24	F241-D Facility timely submits this response plan of correction pursuant to feder state law requirements. This respond plan of correction are not admored or an agreement that a deficiency exist or that a statement of a defice was correctly cited or factually base it's not to be construed as an admagainst interest of the facility, the administrator, of any employees, a or other individuals who participated drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care to promote care for residents in a and in an environment that maintal enhances each resident's dignity are spect in full recognition of his or individuality. To assure continued compliance, the following plan has been put into plants. An interview with resident to obtain preferences completed on Reside on 10 Nov 15 and was offered alterested on the state of the s	ral and onse issions does iency ed and ission agents ed in the or Center manner ins or and her he ace; n 1 126 irrnative cts etc. o ance nealth I be ed with using oileting oileting		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	felt this was undig (FM)-D was prese R126's statements were accurate. O stated he had a broad again placed when finished utni with clean up. R1 "I just feel so help visible tears in his continue the intersurveyor return lat On 10/26/15, at 10 not prefer to use r while waiting for s "That is how I hav system." He did he was unable to impairments, and presented to him wear, "A big diape offerd a disposabl collect fluids). Againing the intervie and feelings of he over when they ar When interviewed nursing assistant R126 in the past we soiled newspapers had never asked I newspapers befor was having to use assisted him.	nified. R126's family member nt for the interview, and stated is of lack of toileting aftercare n 10/23/15, at 7:03 a.m. R126 owel movement that morning, newspaper underneath of him I staff were able to assist him 26 became tearful, and stated, less." R126 continued to have eyes, stated he could not view, and requested the	F 241	updated to reflect residents prefer for maintaining as much independ possible. 2. Actions taken to identify other poresidents having similar occurrence. Direct care staff interviewed by 13 and verified Resident 126 is the or resident with this preference. 3. Measures put in place to ensure deficient practice does not recur: Facility policies reviewed and revisioneded related to Resident Rights and Toileting. Education will be completed with care staff by 13 Desident MDSs will be completed upon admitted a comprehensive bladder assessment. 4. Effective implementation of action be monitored by: Facility will complete five audits of residents using the modified CMS Resident Interview Observation or modified CMS QIS Non-Interviewal Resident Observations and facility complete five NAR Care Observation weekly for three months. The data collected will be presented to the CAssessment & Assurance Committed Quarterly. At that time the Quality Assessment & Assurance Committed Regarding any necessary follow-up needing to be continued. 5. Those responsible to maintain	ence as otential es: Dec 15 nly sed as , Dignity ec 15. nission, ge to ons will QIS able will ions Quality tee ttee will on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245513	B. WING		 	10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	prefer the use of a IRN-H was unaware underneath of hims with clean up, and a were available and stated she expected R126 was observed manner. During interview on director of nursing (unaware R126 was to protect his bedding assistance with clear "innovative" solution pads were not routifully could have been a letter submitted p 10/27/15, authored DON and R126 not his trapeze to pull hon the bedpan for a reach to clean mysty white. I don't want to pan out I put the nekeep from getting must may light on for some pan and clean mean whows we are busy for himself. As indicated that he was dignity was being conself-action." A letter submitted p	ge 31 ried, but R126 tended to bedpan over a commode. R126 was placing newspaper elf until being assisted by staff added several other products could be used. Further, RN-H distaff to report it to her if distaff to her if d	F 2	241	compliance will be: The Director of Nursing is responsicompliance. Completion date for certification puonly is: 29 Dec 15		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 241 F 242 SS=D	the newspapers un arrival. He had the himself on bedpan, was done." A letter submitted p 10/30/15, authored to use newspaper utold him he didn't nechange linen if it go newspapers under A facility policy relatiservices was reques 483.15(b) SELF-DE MAKE CHOICES The resident has the schedules, and heather interests, assessinteract with membinside and outside to the schedule of the schedules.	have his light on but he put der him prior to the [NAs] bedpan within reach and put notifying staff only when he lost survey exit, dated by NA-D noted, "[R126] chose under himself even though I leed to do that and we would be soiled. He continued to put him." Ited to dignified care and sted, but was not provided. ETERMINATION - RIGHT TO the right to choose activities, alth care consistent with his or is sments, and plans of care; ers of the community both the facility; and make choices is or her life in the facility that	F 241		12/29/15	
	by: Based on interview facility failed to hon 3 residents (R73) re Findings include: R73's admission M 10/1/15, indicated reded assist of tw	NT is not met as evidenced and document review, the or bathing preferences for 1 of eviewed for choices. Inimum Data Set (MDS) dated he was cognitively intact, so staff with bathing, and it was be able to chose the method in ed.		F242-D Facility timely submits this response plan of correction pursuant to feder state law requirements. This respond and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficiency was correctly cited or factually base it's not to be construed as an admits	al and nse ssions loes ency ed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 242	R73's care plan da been admitted in Sidentify any prefere required with bathin Assistant Care She bath on Thursday & During interview 10 stated hospice is to week and the facili me two baths a we only received two have been here." The facilities Mill C Vital List dated 9/2 following: The week of 9/2t identified on the basy The week of 10/5 scheduled to receive bath documented a scheduled to receive two baths documented a scheduled to recieve two baths documented to had one bath documented to had one bath documented a scheduled to recieve two baths documented to had one bath documented a scheduled to recieve two baths documented to had one bath documented a scheduled to recieve two baths documented to had one bath documented a scheduled to recieve two baths d	ted 9/25/15, identified he had eptember 2015, but did not ences or assistance R73 ng. R73's undated Nursing eet indicated he received a tub by an outside agency. 0/21/15, at 10:02 a.m. R73 be giving me two baths a ty is supposed to also be giving ek. R73 then stated, "I have baths from the facility since I reek Bridge Weekly Bath and 1/15 to 10/22/15, identified the 1/15 to 9/27/15, R73 was not atth list. B/15 to 10/4/15, R73 continued	F 24	against interest of the facility, the administrator, of any employee or other individuals who participed drafting or who may be discuss otherwise identified the same. It is the policy of Lake Ridge Cato honor resident's bathing preference on the preference on the preference on 27 Nov 15 to verpreference on 27 Nov 15 to verpreference expressed on 21 Oplan and NAR guides updated resident preference of baths perference will be assisting with rebathing preferences giving two week and facility providing two w	s, agents pated in the ed or are Center erences. e, the place; r bathing ify resident tot 15. Care o reflect r week; esident baths per r potential ences: uestioned t QIS pe updated ure r: rviewing ing th acility ing was ff and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 242	not documented on completed.	o his choice adding if it was the listing, it was not hoices was requested, but	F 2	242	with bathing preferences and honoring Resident choices by 13 Dec 15. 4. Effective implementation of actions be monitored by: Facility will complete five audits of residents using the modified CMS QResident Interview Observation or modified CMS QIS Non-Interviewables Resident Observations and facility work complete five NAR Care Observation weekly for three months. The data collected will be presented to the Quassessment & Assurance Committed quarterly meeting. At that time the Quasterly meeting. At that time the Quarterly meeting. At that time the Quarterly meeting and the decision of the presented to the Quarterly meeting. At that time the Quarterly meeting and the decision of the presented to the Quarterly meeting. At that time the Quarterly meeting and the decision of the presented to the Quarterly meeting. At that time the Quarterly meeting and the decision of the presented to the Quarterly meeting. At the presented to the Quarterly meeting and the presented to the Quarterly meeting. At the presented to the Quarterly meeting and the presented to the Quarterly meeting and the presented to the Quarterly meeting. At the presented to the Quarterly meeting and the presented to the Quarterly meeting. At the presented to the Quarterly meeting and the pre	s will IS le vill ns vality ee Quality ee will udits	
	must listen to the vi grievances and reco and families concer operational decision life in the facility.		F 2	444			12/29/15
	by: Based on interview	and document review, the			F244-E		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 244	facility failed to prove resident council growith inadequate state affected 5 of the 48 R35 and R21) who council meetings for Findings include: During the recertific council minutes we following: The resident council takes for the Writer [activity direct difference between vs. [versus] being slacked any further cresidents, or develor R27, R19, and R45 staffing. A follow upform dated 8/12/15 (DON) provided a residents are requestime. We are getting quickly as possible Some employees a while they are learn The resident council dentified, "Updates were addressed, he R35 again stated," need of more nursed on thave enough is the nature of the to be busy and to up waiting for assist with the state of the to be busy and to up waiting for assist with the state of the to be supplied to the state of the to be supplied to the state of the to be busy and to up waiting for assist with the state of the to be supplied to the state of the state of the total state of the state o	vide timely follow-up to the pups grievance as concerned ffing in the facility. This residents (R27, R19, R45, regularly attended resident om 7/28/15 to 9/29/15. vation survey, the resident re reviewed and identified the re reviewed and identified the fill minutes dated 7/28/15, sing R27, R19, R45, "All feel ough nursing help due to how in call lights to be answered. Pattern (AD)] explained the cutting hours due to census hort staffed." The minutes discussion, input from the expense of a plan to address to voiced concerns with the Resident Council Action of the firm the director of nursing esponse which identified, the day and night when many esting assistance at the same and to each one of them as we are adequately staffed. The minutes are adequately staffed.	F 2	244	Facility timely submits this responsiplan of correction pursuant to feder state law requirements. This responsition are not admit or an agreement that a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of exist or that a statement of a deficiency of the facility, the administrator, of any employees, agonor other individuals who participated drafting or who may be discussed on otherwise identified the same. It is the policy of Lake Ridge Care of the provide timely follow-up to reside council groups' grievances and contregarding inadequate staffing in the facility. To assure continued compliance, the following plan has been put into plant 1. Regarding cited residents: The Administrator reviewed most reflected to the plant of the facility is utilized address related staffing concerns. Resident Council monthly minutes are report back to Resident Council at a next meeting in December to follow with action steps the facility is utilized address related staffing concerns. R19, R45, R35 and R21 will be inviting the by December Resident Council follow-up to resident concerns will be addressed. 2. Actions taken to identify other potential reconstruction of the most recent Resident Council minutes were reviewed by Administ minutes were reviewed b	al and onse ssions loes ency ed and ssion gents d in the or center ent ocers. Center ent ocers ecent and will the or my to R27, ted to where be estial es:	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245513	B. WING	B. WING		10/26/2015	
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	,	, , , , , ,	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
address R27, R21, concerns with staff Council Action Forma response by the to run ads & hire nowith retention too! times with a picture it]!" The resident council about staffing. Write requirement for a Noregistered] to be also need assist to eat a reason he had to with the repeated concestaffing at the facilis management team During interview or stated she did not the council meeting. "They are so short sometimes I have to help me you see to get on the bed picture movement, and write an accident pleasant for me." During interview or who stated she is in council meetings. complain about the problem everywhell their concerns. I a	evelopment of a plan to R19, R35, and R45's voiced ing. A follow up Resident m dated 8/25/15, completed as DON indicated, "We continue ew employees continuously Thank You [underlined several e of a smiley face drawn next to be continued to the continue several e of a smiley face drawn next to be continued to the continued to th	F 244	identify additional resident compensured follow up was complete 3.Measures put in place to ensure deficient practice does not recure Facility Administrator reviewed a revised Grievance and Complain policies, and education was proved Department Heads on 23 Nov 18 grievances. An update on the assurvey will be presented at the Factive implementation of active monitored by: 4.Effective implementation of active monitored by: Administrator will review Resider minutes to ensure follow up has completed following every Reside Council meeting for six months. Collected will be presented to the Assessment & Assurance Commendar at that time, the QA&A commendare the decision/recommendare garding any necessary follow-to needing to be continued. 5.Those responsible to maintain compliance will be: The Administrator is responsible compliance. Completion date for certification only is: 29 Dec 15	d. re : nd nts rided to 5 on nnual desident tions will the Council been ent The data e Quality nittee Director, mittee will tion up audits		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 244 F 250 SS=G	complaints of staffir continued at the 8/1 council meetings w plan being identified staffing. The facility Grievan dated 1/12/12, indice Ridge Care Center that enhances reside and peace of mind the opportunity to vour facility." The poresident, their represended to bring of the appropriate of 483.15(g)(1) PROV RELATED SOCIAL The facility must proservices to attain or practicable physical well-being of each in this REQUIREMENT.	R45, R35 and R21 had ng on 7/28/15, their concerns 3/15 and 9/29/15 resident ith no objective, measurable doto resolve there concerns of ces and Complaints policy stated "it is the policy of Lake to provide and environment lent dignity, security, comfort by allowing residents and staff poice their concerns to improve olicy further indicated "If a resentative, family member or or cern with any aspect of care, or the facility; they are go that concern to the attention department manager." ISION OF MEDICALLY SERVICE Divide medically-related social maintain the highest I, mental, and psychosocial resident.	F 24	50	12/29/15	
	review, the facility for related social service provided for 3 of 4 reviewed for social	ion, interview, and document ailed to ensure medically ses needs were identified and residents (R29, R28 and R56) services. This resulted in all harm for R28, who billity to sleep, and		F250-G Facility timely submits this response a plan of correction pursuant to federal state law requirements. This response and plan of correction are not admission an agreement that a deficiency does exist or that a statement of a deficience.	and se ions es	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/	26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 250	demonstrated sign concerns with her Findings include: R29's quarterly Mi 8/25/15, indicated cognitive impairmed depression. R28's quarterly MI resident had seven had dementia with indicated R28 was sleeping, had little herself, and had tr R28's Care Area A 6/12/15, indicated antidepressant, for R28's care plan dadepressed and was encourage expres possible reasons fenvironmental/psy medical conditions management plan sertraline (Zoloft).' had the potential for cognitive loss, and discuss behaviora as needed, and expsychological reference.	nimum Data Set (MDS) dated the resident had severe ent and had dementia with DS dated 9/1/15, indicated the re cognitive impairment, and depression. The MDS depressed, had trouble or no energy, felt bad about ouble concentrating. Assessment (CAA) dated the resident received Zoloft, and rediagnosis of depression. Atted 9/11/15, indicated she was as to receive one to one visits to sion of feelings and to, "Explore or the resident's distress (e.g., rehosocial stressors, treatable is, etc); Implement a mood to compliment drug therapy: The care plan indicated R28 or abuse from others related to it the approach was for staff to it issues with the team members reluated the need for real and evaluation.	F 25	was correctly cited or factually it's not to be construed as an against interest of the facility, administrator, of any employe or other individuals who partic drafting or who may be discus otherwise identified the same. It is the policy of Lake Ridge of the provide medically-related services to attain or maintain practicable physical, mental apsychosocial well-being of ea. To assure continued compliar following plan has been put in 1. Regarding cited residents: Resident 28 and family were by Social Service and was more private room on 12 Nov 15. It was seen by Associated Psychological Service and was more private room on 12 Nov 15. It was seen by Associated Psychological Service and was more plan. Resident 29 discharged to an on 23 Nov 15 to accommodate care needs. Family care conference held of Resident 56, spouse, social servicewed with resident including appropriate snacks available.	admission the es, agents sipated in the sed or Care Center ocial the highest nd ch resident. Ince, the to place; Interviewed oved to a Resident 28 hology and were added other facility e memory with ervices, I corporate etic diet ng Resident	
		tes reviewed from 7/09/15, to d the following incidents related 8's roomate:		and spouse were both able to on education they received or counting, portions sizes, read labels and risks of not following	voice back carb ing food	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0,2010
LAKE RI	DGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	On 7/9/15, "Res. [r Res. is stating how used to make her like it. Res. has all asks so many que she is getting tired. On 7/15/15, a note indicated "Resider rooming situation. much sleep becaunight talking, delus accusing resident lot and is in hopes consoled resident she could do about On 8/24/15, resided dispute. R28 state and she became ushe was done deal wanted a new room On 8/25/15, a progindicated, "Spoke roommate last night with her roommate different room toda want to talk to her only the weather. Vertiletting resident known commate about a On 9/1/15, "Resider roommate blocking Resident when in reside of room to make the control of the commate blocking Resident when in reside of room to make the control of the commate blocking Resident when in reside of room to make the control of the commate blocking Resident when in reside of room to make the control of the commate about a commate of the commate about a commate of the commate about a commate about a commate of the commate about a commate a co	resident] has been crying today. If when she was little her mome watch the baby and she didn't so been say that her roommate stions and needs things and. If documented by activities at is having a hard time with her she says she is not getting se roommate is up a lot at sional as to where she is and of things. Resident is crying a of changing rooms. Writer and said she would see what to the situation. If the situation. If the situation is the situation is the situation in the situation in the situation is the situation in the situation in the situation is the situation in the situation in the situation is the situation in the situation in the situation is the situation in the situation in the situation is the situation in the situation in the situation is the situation in the situation in the situation is the situation in the situation is the situation in t	F 2	250	diet. Resident was able to site complications of uncontrolled diabet that included problems with wounds heart, kidneys and vessels. We revealthy snack options and reminde that facility provides them. Follow appointment scheduled with diabetic educator in early December. Level II PASRR completed on 11/5/stated that "This person's medical and health needs are such that he/she requires NF services. This person admitted to the NF on 9/10/15" also "This person's medical and health needs are so severe that, in the judgement of the QDDP, the person cannot be expected to benefit from treatment." Social Services will conto work with County Social Worker clarifying resident's needs. 2. Actions taken to identify other pot residents having similar occurrence Social Service reviewed care conferom past quarter to identify possible additional residents with room-mate concerns with no further action need A diagnosis list was run from the fasoftware to identify other residents related diagnosis of Developmental Disability or related condition to detif any other residents met criteria for level II screening and need for activate treatment. 3. Measures put in place to ensure deficient practice does not recur: The facility implemented a daily IDT morning meeting with Social Worker attendance to discuss social services.	s, eyes, iewed of them up ic control of them up ic control of the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	` /	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	•	-0/-010	
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 250	on me; up at 1 am room, did leave a r worker], 1 on 1 wit this time." On 9/10/15, reside well last night statisher up asking who On 9/10/15, progreindicated, "Writer vres stopped writer stated 'I just saw ocourt! I have nothimy money! When money she was now was then coming of that little bitch! She night!' Writer let resome one names. roommate got closshe just wants to sroommate. Writer direction but it took there separate way my room' and 'she screws him, she is eat- I don't even workers and she stated she on 9/23/15, reside with the lady in her Resident stated sho one was given.	nd, my roommate is rubbing off. Talks of wanting a different message for SW [social heresident, and was effective at an temperature of the lady in her room kept she is and where she is. The sess note from social services was walking down the hall and and was upset because she in TV that I am being taken to ing, this is not fair they stole all writer asked who stole her it able to say. Res roommate but of the room and res said 'oh is know that was not nice to call Writer asked who him was and er res said 'oh look here she is crew' and she shook her fist at directed ladies in opposite a some time for residents to go its. Res kept stating that 'this is goes in there all the time and such a little bitch, I cant even	F 2	and/or room-mate conce educated on overview of to resident altercation an and resident non-complia 15. MDSs will be comple admission, quarterly and change to include non-corisk versus benefits. 4. Effective implementation be monitored by: Facility will complete five residents using the modified CMS QIS Non-IResident Observations with quarter. The data collect presented to the Quality Assurance Committee quality Assurance Committee quality and continued. 5. Those responsible to make the CAS and completion date for certionly is: 29 Dec 15	PASRR, resident d interventions ance by 13 Deceted upon with significant ompliance and on of actions will audits of fied CMS QIS rvation or nterviewable reekly times one ted will be Assessment & Juarterly. At that e will make the n regarding any ts needing to be maintain ervices is ce.		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245513	B. WING				26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310	EET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD FFALO, MN 55313	100	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	computer res. statir res was asked whan neck- I don't sleep Res. stated 'I really any sleep with her i relief. SS updated. On 10/6/15, social sresidents daughter concerns that resid who was after her asleeping with all sor just wanted to complete graph wanted state graph wanted state graph wanted state graph wanted to wante graph wanted graph wante	ng 'I wish I had one of those' t? 'That cord for around my cause of that lady in my room.' wont do that but I never get n there.' 1 on 1 was given with	F 2	250			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245513	B. WING		· · · · · · · · · · · · · · · · · · ·	10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310	REET ADDRESS, CITY, STATE, ZIP CODE D LAKE BOULEVARD IFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	tomorrow. On 10/20/15, "Write assistant registered said she was going daughter to inform asked aides what he roommate didn't was aid she didn't was aid she didn't wan the claim that room Aides said roommate make such a commate separated at this tirbed." On 10/22/15, social with resident and don 10/20/15. Resisted her roommate was going she felt safe and with She stated her room that's all and sometimes. Asked her roommate during times resident came to with because of all of her rooms and at her and Because she was slike hurting herself think so."	age 42 uld call the social worker er informed by NAR (nursing d) that Res claims roommate to cut her throat. Res called daughter of situation. Writer nappened. Aides said ant to go in room because Res ther there. Then Res made mate said she'd cut her throat. At the wasn't even around Res to ment. Res and roommate me. Res on her way back to I service note indicated "Met iscussed comments she made stated that she did not feel her mg to slit her throat, res stated as not afraid of her roommate. In mate just wants the whole she just gets that way is res twice if she felt safe with mg the conversation and both er hands at writer and said oh I service note indicated riter upset with roommate er visitors and that she needed on because her roommate d shuts the door on her. So upset writer asked if she felt and res stated, "No, I don't dent was up at the front door gout of here.' Writer told	F 2	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE	
F 250	out there. Resident rain. I'm not staying these awful people was resistant at firs go to the Vineyard. social services and put a Wanderguard. An Associated Clini dated 8/17/15, indicand did not have surecommendations when she voiced. A Geriatric Services dated 9/10/15, indicated 9/10/15, indicated 9/10/15, indicated 9/10/15, indicated 10/15, in	ing out. You don't want to go replied, I don't care about the ghere another night; live with here, I'm leaving. Resident to the tout then writer got resident to Writer reported this info to nursing. At this time nursing on resident." To of Psychology visit note ated R28 had depression, icidal ideation. The vere to use validation are appeared to have concerns, concerns. To of Minnesota physician visit ated, "The patient [R28] did any while complaining about commate. I spoke with various of the patient has had problems the of other roommates and I candidate for a private room." To facility staff, "I will be happy request for a private room."	F 2	250				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		245513	B. WING _	B. WING 1			
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 250	roommate because uncomfortable." R "Doesn't like being be "unsettled" above with R29. R28 had times a week of not because of R29, a were reported to selected she had specified in the want the resirather just wanted pictures and music space of the room R28's daughters had change rooms because," between R28 stated, "Nothing ex R29 rooming toget During interview 10 stated R28 and R2 [R29] is very forger minutes to the nex room she is on and things and it upset upset and will go of her family; she has never told me she suicide checks. We charting to separate charting. It would be separated." During interview 10 practical nurse (LF R29] fight a lot. I have	e R29 was, "Making her 28 had expressed she, in that room," and continued to ut having to remain in the room d ongoing episodes several of sleeping well at night and NA-T stated these concerns ocial worker (SW)-A, but SW-A oken to R28's family and they dent to change rooms, but the facility to add some to try to enhance the physical for R28. NA-T stated one of add recently visited from out of expressed desire for R28 to sause she could, "See how it and R29; however, NA-T ver got done," about R28 and	F 25				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 250	frustrated, they dor and about what wo be compatible with [R28] to move to rebecause I felt her a be a good fit and the tells me she wants that she wants to k "I don't think things occur." LPN-A statit with each other in During interview 10 stated, "I have never my life." R28 state present at the time Kleenex. R28 state room, I want a differ gals that work here wiping her tears with began rubbing her am so tired of this, mind to end my life have to put up with roommate (R29), "I p.m., R28 was still During interview or worker (SW)-A state aware R28 and R2 stated she and the discussed moving frooms, but felt it we either one of them. hallucinates and haman being in the roman around. SW-roman around. SW-roman around. SW-roman around.	with it and the staff are very at ask us about room changes uld work best, and who would who. I suggested for her som 126 when that was open and the other roommate would be never moved her. [R28] to move [R28] says things ill herself." LPN-A then stated, are charted as often as they ed R28 and R29 just, "Got into a the hall." 1/26/15, at 4:23 p.m. R28 are been treated like this ever in ed to cry, and LPN-A (who was of interview) gave her a ed, "I have asked for a different erent room, and I have told the entat!" R28 continued to cry the her Kleenex. R28 then head and stated, "Oh my god I have it in the back of my. I am 86 years old, why do I this?" R28 stated her is nastier than nasty." At 4:33 crying. 10/26/15, at 4:36 p.m. social and ed everyone at the facility was 9 did not get along. SW-A director of nursing (DON) had the residents to separate ould not be a benefit to move	F 2	50			

Author A		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO QUAJ ID (EACH) DETECION WITH STATE MENT OF DEFICIENCIES (EACH) DETECION WITH STATE MENT OF DEFICIENCIES (EACH) DETECION WITH STATE PROVIDERS PLAN OF CORRECTION (EACH) DETECION WITH STATE PROVIDERS PLAN OF CORRECTION FROM TAG. F 250 Continued From page 46 had asked R28 about her suicide thoughts and she had never had a plan. SW-A stated she had offered to move R28 to a different room, however, her daughter in law did not want her to move. SW-A stated the facility did not currently have any private rooms available, and the empty rooms all have roommates, and the facility felt they would rather wait for a private room because she will wait until the resident was actually moved into the room, and there might be a couple opening in the near future. SW-A stated R28 had been seen by the Associated Clinic of Psychology and they were to be seeing R28 on a monthly basis, however, the last time visit was 8/17/15, and there currently was not a follow up appointment scheduled. SW-A stated she would need to call the Psychology clinic being it had been a few months, because the Psychologist was, "Not very good about keeping her schedule with the residents here." During interview 10/26/15, at 5:07 p.m. R28's family member (FM)-A stated she was aware of R28's concern with her roommate, and the resident does complain to her about it. FM-A was not aware the physician had recommended a private room for R28, nor had the facility spoken			245513	B. WING		10	/26/2015		
FREEIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 250 Continued From page 46 had asked R28 about her suicide thoughts and she had never had a plan. SW-A stated she had offered to move R28 to a different room, however, her daughter in law did not want her to move. SW-A stated the facility did not currently have any private rooms available, and the empty rooms all have roommates, and the facility felt they would rather wait for a private room to open before moving R28. SW-A stated she had not filled out a waiver for a private room because she will wait until the resident was actually moved into the room, and there might be a couple opening in the near future. SW-A stated R28 had been seen by the Associated Clinic of Psychology and they were to be seeing R28 on a monthly basis, however, the last time visit was 8/17/15, and there currently was not a follow up appointment scheduled. SW-A stated she would need to call the Psychology clinic being it had been a few months, because the Psychologist was, "Not very good about keeping her schedule with the residents here." During interview 10/26/15, at 5:07 p.m. R28's family member (FM)-A stated she was aware of R28's concern with her roommate, and the resident does complain to her about it. FM-A was not aware the physician had recommended a private room for R28, nor had the facility spoken					310 LAKE BOULEVARD	-			
had asked R28 about her suicide thoughts and she had never had a plan. SW-A stated she had offered to move R28 to a different room, however, her daughter in law did not want her to move. SW-A stated the facility did not currently have any private rooms available, and the empty rooms all have roommates, and the facility felt they would rather wait for a private room to open before moving R28. SW-A stated she had not filled out a waiver for a private room because she will wait until the resident was actually moved into the room, and there might be a couple opening in the near future. SW-A stated Ske had been seen by the Associated Clinic of Psychology and they were to be seeing R28 on a monthly basis, however, the last time visit was 817/15, and there currently was not a follow up appointment scheduled. SW-A stated she would need to call the Psychology clinic being it had been a few months, because the Psychologist was, "Not very good about keeping her schedule with the residents here." During interview 10/26/15, at 5:07 p.m. R28's family member (FM)-A stated she was aware of R28's concern with her roommate, and the resident does complain to her about it. FM-A was not aware the physician had recommended a private room for R28, nor had the facility spoken	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION		
to her about moving R28 to a different or private room. During interview 10/26/15, at 6:03 p.m. DON stated a lot of the staff know there, "Is a clash between [R28] and [R29]." The DON stated she was not aware where the social worker was at	F 250	had asked R28 at she had never had offered to move F however, her daumove. SW-A stat have any private rooms all have rooms and the room, and the rooms all have rooms scheduled. SW-A the Psychology cl months, because good about keeping residents here." During interview 1 family member (FR28's concern with resident does connot aware the phy private room for From to her about moving room. During interview 1 stated a lot of the between [R28] and stated a lot of the between [R28]	cout her suicide thoughts and d a plan. SW-A stated she had a 28 to a different room, ghter in law did not want her to ed the facility did not currently rooms available, and the empty commates, and the facility felt wait for a private room to open as. SW-A stated she had not for a private room because she esident was actually moved into are might be a couple opening in asw-A stated R28 had been seen Clinic of Psychology and they a R28 on a monthly basis, time visit was 8/17/15, and as not a follow up appointment a stated she would need to call inic being it had been a few the Psychologist was, "Not very ng her schedule with the 0/26/15, at 5:07 p.m. R28's M)-A stated she was aware of the her roommate, and the applain to her about it. FM-A was resician had recommended a R28, nor had the facility spoken ng R28 to a different or private	F2	250				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	them." DON stated comments from R2 made a comment a around her neck, at that, she had a plar R56's undated Residentified diagnoses bipolar, anxiety, demental disorders ducondition. R56's Initial Pre-Ad Results based on in 9/9/15, by the Buffa SW-C, identified shintellectual disabiliti "Based on the infornursing home stay, the criteria for DD [Ineeds to be referred evaluation. Please in need for referral for made by Senior Lin 1 screening dated SWright County case R56 did not have a related condition (Diconsidered to have evidence that might of DD/RC, and had or boarding care fact that served persons additional PASRR In 9/11/15, was maintarecord. This screen registered nurse (R	ey haven't moved one of I she heard about suicidal 8, but was not aware R28 bout wanting a cord for nd stated, "If she [R28] said	F 2	250			

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTIC NG		(X3) DATE SURVEY COMPLETED		
		245513	B. WING	NG			26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS 310 LAKE BOULI BUFFALO, MN		,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 250	declared R56 did have vidence was presente presence of DD identified, no referra a PASRR level 2 expursue clarification screenings, to ensuappropriate support Her admission MDS cognition was intact assistance for most (ADLs), but require for eating. The MDS therapeutic diet and The CAA dated 9/1 assistance with all for hypoglycemia. Notaff to participate. She maybe looking foster home. Husbate for her." The CAA mull with good intaked R56's care plan dat provide her with a context of the care plan did not fure direct interventions management of her disability, or direct of the facility and R56 to the receive support R56 in redisability, or direct of the facility and R56 to the facility and R56	ave a DD/RC and presenting ent that may have indicated /RC. Though conditions were all was made for completion of valuation. The facility did not of these conflicting are R56 received the tis. So dated 9/17/15, identified her tis and required extensive to activities of daily living donly supervision and set up is identified R56 was on a difference in received insulin medications. 7/15 noted,"[R56] is needing ADLs following hospitalization leeds encouragement from Discharge plan is uncertain, at moving to a group home or and is having difficulty caring noted R56 was on a lated to her diagnosis of noted, "Resident tolerates diet are and good glucose levels." red 10/22/15, directed staff to diabetic diet of mechanical soft lan directed R56 was to and set up for eating. The rither address R56's diet,	F 2	50				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		COMPLETED		
		245513	B. WING _		10.	/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
F 250	injection; one dose blood glucose whe sugar by mouth, st Lantus 100 units/ r subcutaneously inj for diabetes, with d Novolog 100 units/ injecting before brebefore supper and was less than 150, adjusted on 10/23/ Novolog Flexpen 1 (200-250 = 3 units, 8 units, 351-400 = subjutaneously injellunch and before s dosing adjusted on Accucheck (blood a.m., 7:00 a.m., 11 p.m. daily, ordered Diabetic diet with n with an order date "Very important for diet. All junk food s patient's room." The directive was 10/14 Review of R56's Vithrough 10/26/15, ilevels were unstable extreme lows. Blood glucose read (dL) and over 500 (9/12/15 (45 mg/dL), 9/24/1 mg/dL), 10/2/15 (5.5)	am (mg); intramuscular as needed for severe low n R56 was unable to take arted on 10/2/15. nilliliter (mL) 30 units; ecting once daily at bedtime, losing adjusted on 10/23/15. mL 6 units; subcutaneously eakfast, before lunch and holding if R56's blood glucose for diabetes, with dosing 15. 00 units/mL sliding scale 251-300 = 5 units, 301-350 = 10 units, >400 = 12 units); ecting before breakfast, before upper, for diabetes, with 10/23/15. glucose monitoring) at 3:00 :00 a.m., 4:00 p.m. and 7:00 on 10/23/15. pechanical soft textured food, of 10/2/15. patient to be on a diabetic should be removed from e order start date for this	F 25	50				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, 310 LAKE BOULEVARD BUFFALO, MN 55313	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 250	mg/dL), and 10/23/(532 mg/dL). Review of progress 10/26/15, included education provided diabetic diet and/or with her diet: On 9/15/15, at 8:25 noncompliant with [with resident this exbutter] sandwich, 2 resident all of which snack." On 9/16/15, at 4:21 noted, "[R56] would regarding her meals On 9/17/15, at 9:13 (CDM)-A noted, "Sabreakfast and discuunsure of what she to order on a diabet carbs [four to five cand to go for health the chips and pop. gave her some read also gave her a mir order and still be in On 9/17/15, at 9:15 nutritional assessm included, "Resident She is independent member has set he 76-100%. She is ind and has been counhave per meal and Also for HS snacks and small milk. She	notes from 9/10/15, through the following evidence of to R56 in relation to her concerns of noncompliance p.m. LPN-D noted, " diabetic] diet; spouse in to visit rening; brought in PB [peanut [two] bags chips and soda for a she ate for HS [bedtime] p.m. registered nurse (RN)-C like to talk with the dietician s. Message left with manager." a.m. certified dietary manager at down with resident at assed her diet. Resident was was supposed to eat and how ic diet. We talked about 4-5 arbohydrate choices] a meal y carbs like fruits vs [verses] We spoke about sugars and I ding materials on diabetes. I ni meal cheat sheet to help her	F 2	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10	/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 250	changes." On 9/21/15, at 12:0 noncompliant with numerous snack w Encouraged to no causing hi BS [high understanding and coke." On 9/23/15, at 11:1 is not compliant wit resident does usual items, resident eats a large amount of sroom." On 10/13/15, at 10 "Resident has beer [and] yesterday mo On 10/15/15, at 5:2 left facility again to to KFC and will r/t [On 10/21/15, at 2:0 "Resident has beer appropriate meal son 10/22/15 at 1:2 "Resident's husbar lunchtime." On 10/22/15, at 11:1 "Resident noncomplas variety high careviewed diabetic of 1 like these." On 10/23/15, at 12:1 "Appetite is good; on high carb snack [primary medical dodiet."	weights and intakes for 00 a.m. LPN-I noted, "Appears diet ie: drinking large coke and					
		diabetes and food choices."					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245513	B. WING		10	/26/2015
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 250	During interview or eported R56 had prompted by hypo R56 had not had a facility, she did had when she lived at from hypoglycemic hospitalization just facility. RN-H state extremely erratic at then way low. She non-compliant with longstanding issue She stated facility about her diet and should or should rhad to honor her rathem take snacks R56's husband was her. She added, fa all of the time, with During interview of practitioner (NP)-ER56's diet non-con R56 had the capadecision about her that is why we are group home." NP-medical doctor had the Wright County SW-D, who was a discussed discharshe was schedule the following week allow R56 to return services. However	n 10/23/15, at 7:33 a.m. RN-H a seizure earlier that morning, glycemia. She stated, though a seizure since admitted to the ve a history of this occurring home. RN-H reported a seizure a was what had resulted in the t prior to her admission to this ed R56's blood sugars were and that they wient way high, said that R56 was a her diet and this had been a e from prior to her admission. staff talked with her frequently educated her on what she not have been eating, but they ight when she declined to let out of her room. RN-H stated as bringing lots of snacks in for accility staff tried to educate him	F 2	250		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			310	REET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD FFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	leave and go homedid not allow in-hoprovide the support "Really the only was would be to comme husband, also did decisions on her bof whether SW-Dathis time. NP-B start medical doctor we working plan. NP-I to honor R56's choto remove the snathe was not surprissoda pop were obsthroughout the west During observation 1:00 p.m. R56 den her about how to reconfines of her die talk to her about with She stated they to bread and fruit. R5 allowed the staff to if they wanted to. Siff they could remove stated she knew her compliance with her hus potato chip bags with R56's resident roo opened, with appropriate interview of the staff to go the staff to go they wanted to state they wanted to staff to go they wanted she knew her compliance with her hus potato chip bags with appropriate she wanted she want	e." NP-B stated R56 historically me service providers to actually it necessary. NP-B reported, ay to get her to follow her diet it her." He stated R56's not have the capacity to make ehalf. He stated he was unsure was pursuing guardianship at ated he and R56's primary re working very hard to find a B stated the facility staff needed pice if she would not allow them cks from her room. He stated ed to learn snacks of chips and served in her resident room	F 2	250			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	STREET ADDRESS, CITY, STATE, ZIP CODE B10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	screening before shadmission, "but the across as not being Senior LinkAge Line facility when a level then a county worker facility to complete reported she did no responsibility to follow come out. When as diagnosis of develow stated she did not smedical record to shospital told her R5 very involved and the potential placement stated, "If you talk weems like there we SW-A confirmed shaded," If you talk weems like there we SW-A confirmed shaded, she did not smedical record to shospital told her R5 very involved and the potential placement stated, "If you talk weems like there we SW-A confirmed shaded it was here compliance with he consultation with reducation materials R56's comprehensitime of interview, S' of chips from anoth stated it was 'contrawas not supposed to stated that it was pastaff to check his roremove anything for there had been any arrangement to be that the other reside which limited his abchoice, but R56 did and therefore, she contractions are supposed to the state of the sta	nen she did her pre-admission ne was accepted as a new in she ended up coming a level 2." SW-A stated in the ended up contacted the ended in the ended up contacted the ended in the end in th	F 2	250			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(E SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP (310 LAKE BOULEVARD BUFFALO, MN 55313	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E	BE	(X5) COMPLETION DATE
F 250	not coordinated wit identify any social social social social services from an inprovider who tried develop a calendar eating. SW-D stated proved successful have the capacity trassociated with fail diet. SW-D stated specialized support compliance with he "definitely" required and the county was pursuance of legal about R56's diagnosome indication of did not see anythin actual diagnosis of However, as the completed for R56 prior. Upon further testing identified ar 63 and included a sintellectual disabilit Report signed 3/25 psychological testinat Nystrom & Assopsychologist (LP)-A a Wechsler Adult In Edition (WAIS-IV), resulting diagnosis disability.	age 55 th the county case manager to service needs for R56. Interview on 10/26/15, at 9:41 R56 had received in-home idependent living skills (ILS) over the past year to help R56 or book to track what she was ad the ILS services had not and that R56 did not appear to comprehend the risks ling to comply with her diabetic she did believe R56 required at to work with her on a currently considering the guardianship. When asked coses, SW-D stated there was a learning disability, but she g in her record identifying an developmental disability. Inversation progressed, SW-D sychological testing that was approximately six months inquiry, SW-D stated the intelligence quotient (IQ) of motation of moderate y. A Psychological Interpretive in the line of moderate on R56 ciates, Ltd by licensed A. The report detailed R56 had intelligence Scale, Fourth full scale IQ of 63, with a of moderate intellectual	F 2	250			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	()	(3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313	ODE	10/10/10/10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BI		ON
F 250	sugars. She state hypoglycemic eve who arrived at the and had indicated similar calls when stated facility staff and her husband she added, "as operson and she cause the only bipolar disease impairments with foster home would guardianship is not asked what adapt the verbal educati provided to R56, t She replied she wadaptations had be added, "Mainly it i When it's snack ti and dietary is invodietary staff take hereommendations." During interview of DON stated the fadepartment was repassed to R56 had a diagno stated, "If I had kr with her where sh	long history of fluctuating blood d, on 10/23/15, when R56 had a nt, the police and paramedics scene were familiar with R56 a history of responses to R56 lived at home. RN-H had done education with R56 regarding her snacks. However, of right now she is her own an make those decisions." ther R56 had the ability to eks of non-compliance with her "Hard one to answer real diagnosis we have is the I think there is some cognitive her Maybe a group home or d be a better option, but of in place yet." RN-H was ations, if any, had been made to on and education materials of optimize her understanding, as unsure whether any een made. However, she is more the staff reminding her me she does have a sandwich of the stated she was not aware stated she did not believe in the facility who required a ne stated she was not aware sis of intellectual disability. She never satility staff had made any her facility staff had made any	F 2	250			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	1
F 250 F 282 SS=D	support to R56 with added, "Her diabete some needs that I t do what we can to it the social worker to specialized support into that." A facility policy add social services was provided. 483.20(k)(3)(ii) SEF PERSONS/PER CATTHE SERVICES provided by the services provided b	regards to her diet. She es is so significant, she has hink are a little different we dentify them I would expect be coordinating that [any es] and then nursing interjected ressing the responsibilities of requested, but was not	F 28		12/29/15	
	by: Based on observative review, the facility for directed by the care reviewed for dental findings include: R5's quarterly Minimal 9/15/15, identified for required extensive hygiene, including the During observation was seated in a recommendation.	num Data Set (MDS) dated R5 had intact cognition, and assistance with personal		F282-D Facility timely submits this response plan of correction pursuant to feder state law requirements. This respondent and plan of correction are not admitor an agreement that a deficiency dexist or that a statement of a deficiency of the state of the facility base it's not to be construed as an admit against interest of the facility, the administrator, of any employees, agor other individuals who participated drafting or who may be discussed of the the same.	al and onse ssions does ency ed and ssion gents d in the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE RI	DGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R5's care plan date an, "Alteration in Aldressing, grooming care plan directed scare am [morning] During interview on stated the care plan [staff] supposed to NA-F helped R5 geoffer or assist him to Further, NA-F state having his teeth brudoesn't develop or a teeth.	asked about his oral health. 2d 7/14/15, identified R5 had DLs [activities of daily living] of and bathing". Further, the staff to assist R5 with, "Oral and pm [evening]" 10/23/15, at 12:55 p.m. NA-F is used to know "what we're do" for the residents care. It ready for the day, but did not so complete oral cares. It is shed and cleaned so R5 al disease, or loose additional	F 2	282	It is the policy of Lake Ridge Care of to provide oral cares as directed by plan of care. To assure continued compliance, the following plan has been put into plants: Regarding cited residents: Resident 5 was interviewed for preferences related to oral care on 15 and care plan/NAR Care guide updated. Oral care audits on Residual be completed periodically as factores delivered according to care plants. 2. Actions taken to identify other portesidents having similar occurrence.	the ae ace; 30 Oct dent 5 cility ral blan. tential	
	stated R5 needs to complete oral care offered his oral care happening." A facility policy rega	ewed on 10/23/15, at 1:04 p.m. RN-A eds to be set up with assistance to all cares, and NA-F should have ral cares, "That's what should be by regarding care plan on was requested, but was not			Residents identified as having pote be affected by area cited are reside who require assist with oral cares. 3. Measures put in place to ensure deficient practice does not recur: Education provided to care related 13 Dec 15 providing oral care and following resident care plans. Resi Care plans and NAR care guides with updated to reflect resident oral care needs. MDSs will be completed updadmission, quarterly and with signification change to include oral care needs. 4. Effective implementation of action be monitored by: Facility will complete five audits of residents using the modified CMS of Resident Interview Observation or modified CMS QIS Non-Interviewal	staff by dent vill be e on ficant as will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		` '	E SURVEY PLETED
		245513	B. WING				10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP COL 10 LAKE BOULEVARD BUFFALO, MN 55313	Œ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 285 SS=D	FOR MI & MR A facility must coord pre-admission screprogram under Medithe maximum exter duplicative testing at A nursing facility must an authority has determindependent physic performed by a personal testing the state mental health (A) That, becaus condition of the indi	e) PASRR REQUIREMENTS dinate assessments with the ening and resident review dicaid in part 483, subpart C to not practicable to avoid and effort. Just not admit, on or after my new residents with: s defined in paragraph (m)(2) neless the State mental health	F 2		Resident Observations and facomplete five NAR Care Observeekly for three months. The collected will be presented to Assessment & Assurance Conquarterly. At that time the Quassessment & Assurance Comake the decision/recomment regarding any necessary folloneeding to be continued. 5. Those responsible to maintacompliance will be: The Director of Nursing is rescompliance. Completion date for certificationly is: 29 Dec 15	ervation data the Quantition dation when a d	uality ee ee will n audits	12/29/15

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER			31	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 285	and (B) If the individ services, whether specialized service (ii) Mental retarda (m)(2)(ii) of this seretardation or develor has determined pr (A) That, because condition of the incention of t	ual requires such level of the individual requires es for mental retardation. ation, as defined in paragraph ction, unless the State mental elopmental disability authority ior to admission-se of the physical and mental dividual, the individual requires es provided by a nursing facility; ual requires such level of the individual requires es for mental retardation. is section: is section: is considered to have "mental dual has a serious mental	F 2	285	F285-D Facility timely submits this respons plan of correction pursuant to feder state law requirements. This response and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficitive was correctly cited or factually based it's not to be construed as an admit against interest of the facility, the administrator, of any employees, as	ral and onse ssions does ency ed and ssion	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		E SURVEY PLETED
		245513	B. WING _		10/:	26/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI		
LAKEDI	DOE OADE OFNITED	OF BUFFALO		310 LAKE BOULEVARD		
LAKE HI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 285	Continued From pa	age 61	F 28	35		
	disorder due to known R56's Initial Pre-Ad	own physiological condition. dmission Screening (PAS)		or other individuals who partic drafting or who may be discus otherwise identified the same	ssed or	
	Results based on i 9/9/15, by the Buffa (SW)-C, identified intellectual disabilit "Based on the information nursing home stay the criteria for DD needs to be referred evaluation. Please need for referral formade by Senior Lintellectual A Fax Transmittal Sthe facility social we Council on Aging/S	Information submitted on allo Hospital social worker she had a diagnosis of mild ies. The screening noted, rmation provided for this, it appears this person meets [developmental disability] and ed to the lead agency for further note final determination of the r further evaluation will be hkAge Line ®." Sheet dated 9/10/15, sent to orker (SW)-A from Central MN Senior LinkAge Line ®, noted		It is the policy of Lake Ridge of to ensure PASRR evaluations completed with a diagnosis of intellectual disability. To assure continued compliant following plan has been put in 1. Regarding cited residents: The facility received a Level I Preadmission Screening from Steuven, Wright County Social 5 Nov 15.	Care Center s are f moderate nce, the nto place; I n Irina al worker on	
	processing, as per identified on a hom services (HCBS)- varies (HC	warded to Wright County for the process for residents are and community based waiver. creening dated 9/10/15, so Wright County case manager to thave a developmental condition (DD/RC), had never to have DD/RC, had no see that might have indicated the C, and had not been referred ding care facility placement by wed persons with DD/RCs. e conditions were identified, no for completion of a PASRR RR level 1 screening dated rained as part of R56's medical along was completed by		2.Actions taken to identify other residents having similar occur. A diagnosis list was run from software to identify other residented dx of Mental Retardat Illness to determine if any other met criteria for a level II screen as Measures put in place to endeficient practice does not reasocial Worker, or their design been educated on PASRR and reviewing Senior LinkAge Lingfor notation that resident may Mental Illness. Social Worked will compare Senior LinkAge Level I and resident diagnosis pertinent diagnosis that would need for a Level II. Social Worked responsible to attach Preadm Screening to resident electrors.	rrences: the facility dents with ion or Mental er residents ening. sure cur: nee, has d will be e PAS forms have DD or r or designee Line PAS, s for d indicate the orker is ission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)) BE	(X5) COMPLETION DATE	
F 285	registered nurse (Fagency identified of declared R56 did hevidence was presente presence of DE identified, no referra PASRR level 2 expension of the presence of DE identified, no referra PASRR level 2 expension of the presence of DE identified, no referra PASRR level 2 expension of the part of the presence of the pre	RN)-F, with no associated n the forms. This screening ave a DD/RC and presenting ent that may have indicated D/RC. Though conditions were al was made for completion of	F 285	record. 4.Effective implementation of action be monitored by: The facility will audit five residents per month for three months, comp Senior LinkAge Line PAS, PASRR diagnosis list to determine if Pre-admission screening Level II vacompleted as required. The data collected will be presented to the CAssessment & Assurance Commit quarterly. At that time the Quality Assessment & Assurance Commit make the decision/recommendation regarding any necessary follow-up needing to be continued. 5.Those responsible to maintain compliance will be: The Social Worker is responsible compliance. Completion date for certification pronly is: 29 Dec 15	charts aring and vas Quality tee tee will on audits		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245513	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	for R56 approximate further inquiry, SW-an intelligence quot notation of moderate. Review of a Psychological destinated at Nystrom & Assoc psychologist (LP)-A a Wechsler Adult In Edition (WAIS-IV), resulting diagnosis disability. Although R56 had to screening complete the facility did not colarify the discrepant to determine if R56 screen completed. A facility policy regarequested, but was 483.25 PROVIDE CHIGHEST WELL BEach resident must provide the necess or maintain the high mental, and psychologist.	I testing that was completed rely six months prior. Upon Desired the testing identified tient (IQ) of 63 and included a te intellectual disability. Diogical Interpretive Report railed assessment and registrative was completed on R56 diates, Ltd by licensed at The report detailed R56 had relligence Scale, Fourth full scale IQ of 63, with a of moderate intellectual and was separate PASRR and by two different individuals, ontact the county agency to not between the two PASRR, needed a level 2 PASRR arding PASRR screenings was not provided. CARE/SERVICES FOR	F 28			12/29/15
	This REQUIREMEN	NT is not met as evidenced				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245513	B. WING			10/2	26/2015
_	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313	10/1	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	review, the facility f assess and develop for 1 of 3 residents R118 voiced compl demonstrated district dressing change will The facility also fail wheelchair position who was leaning significant for the right lower expectage of the required ling activities of daily lividentified R118 did medication, but recommedication and nor interventions for paidentified the pain right, and limed he self-reported number current pain was to 10, numeric pain the most intense	tion, interview and document ailed to comprehensively or interventions to reduce pain (R118) reviewed for pain. aints of unmanaged pain, and essing pain during a wound nich resulted in actual harm. ed to provide proper ing for 1 of 1 residents (R57) gnificantly to the right side. sident Admission Record in including peripheral vascular exact poarthritis in right hip, cellulitis at remity, non-pressure chronic leg non-healing with an ain syndrome, and Trigeminal ain). simum Data Set (MDS) dated R118's cognition was intact inted assistance for most ing (ADLs). The MDS not receive scheduled pain eived as needed (PRN) pain	F3	809	F309-G Facility timely submits this respons plan of correction pursuant to feder state law requirements. This response and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficit was correctly cited or factually base it's not to be construed as an admis against interest of the facility, the administrator, of any employees, agor other individuals who participate drafting or who may be discussed on the otherwise identified the same. It is the policy of Lake Ridge Care of the ending of the en	al and onse ssions does ency ed and ssion gents d in the or Center essary tain the land les for sident wound return nt was ated to rapy,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245513	B. WING		10/26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	10,20,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLÉTION
F 309	verbal description of MDS identified she ulcer at the time of The Care Area Assidentified R118 need to weakness a osteoarthritis, but wherself as possible a stasis ulcer on he and continued to dCAA identified R11 to neuropathy, osteright lower leg. Sta [Ultram, an analge Also uses warm to will continue to mo [medical doctor] as Although the MDS which made it diffied day to day activity, this area to determate a trisk for uncontrol osteoarthritis and sextremity. The care state her pain was analgesic, or show pain. Interventions Encourage R118 in numeric scale as a second of the care plan date at risk for uncontrol osteoarthritis and sextremity. The care state her pain was analgesic, or show pain. Interventions	of the pain even though the had one arterial or venous the MDS. Ressment (CAA) dated 8/24/15, aded assistance with all ADLs and decreased mobility from vanted to do as much for an arge amounts of fluid. The 8, "Is complaining of pain due coarthritis, and stasis ulcer on tes that PRN Tramadol sic medication] relieves pain. Wels and repositioning. Staff nitor for pain and update MD aneeded." Identified R118 had pain, bult to sleep, and limited her the facility had not assessed ine if the pain regime was 18. Ind 10/9/15, identified R118 was alled pain related to stasis ulcer to her right lower to plan goal was for R118 to decreased with the use of an non-verbal signs of decreased included the following: to report pain levels PRN, per a lible.	F 30	,	or otential es: pain. Il have ement per pain s will be d on the ed for Ss will arterly lude a Care air cc 15. stand monitor d w/c ons will e
	reassessing her pa ·Offer R118 comfo	changes in comfort PRN, ain as needed. rt measures PRN, of , cold, massage, diversional		complete five audits of residents u modified CMS QIS Resident Interv Observation or modified CMS QIS Non-Interviewable Resident Obse	riew

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	activities, etc During observation 11:30 a.m. R118 crelated to an open She stated a routin been completed to pain she experience changes was exceover a 10." R118 s giving her pain medressing change the The ice packs, and subside almost, ar like a grabbing pait through the ceiling R118 was frequent and applying ice pater current pain lesis tolerable." R118 an acceptable level on 10/22/15, at 9:2 her room, receiving from licensed pract LPN-F and R118 capain medication to treat liked to wait "for hed dressing change was LPN-F to return in dressing change at 10:01 a.m., R118 s never quite cuts it. there's nothing [that 10:11 a.m., LPN-F dressing change. It room, R118 was at room, R118 wa	n and interview on 10/21/15, at omplained of unmanaged pain sore to her right, lower leg. he dressing change had just of her right leg and reported the ded during these dressing essive, stating her pain "hits tated if the nurses think of dication before and after the ney will, along with some ice. If pain medication at times, "Will had then all of the sudden it is not that almost sends me." During this conversation, the right, lower leg acks to the area. R118 stated wel was, "down to a five [5] it reported a pain rating of 5 was	F 309	weekly for three months. Ten ch will be done monthly for three more pain management. The data col be presented to the Quality Asse Assurance Committee quarterly. time the Quality Assessment & A Committee will make the decision/recommendation regard necessary follow-up audits need continued. 5. Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	onths for lected will ssment & At that ssurance ling any	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	pain scale. At 10:16 R118's resident roo preparations for the about to begin the t "Where's my ice pa forgotten to bring th immediately upon of change. R118 said that now." LPN-F sa retrieved an ice pace dressing change. A the Kerlix (gauze ba highly absorbent dr padding and protect then used a saline a pieces of Silversort slough, by wiping, r colored debris from LPN-F was removir completing debridm wincing, jerking and procedure. At 10:27 eyes, which she wip held in her hand thr During the dressing stop and pause sev and breathe before ready for LPN-F to change she would ther face, and choke voice, and said "oka stated, "Okay, it's s R118 if she had not medication to begin I'm just gonna have the pain." As soon a R118 immediately a	er pain a seven, out of 0-10 is a.m. LPN-F returned to m, completed her edressing change and was reatment when R118 asked, ck?" LPN-F stated she had be ice pack, but would bring it completion of the dressing loudly and firmly, "No. You get aid, "Okay, yes mam." LPN-Fick and then began the to 10:22 a.m., LPN-F removed andage rolls) and ABD pad (a dessing used to provide tion for large wounds). LPN-Ficaerosol spray to slowly remove to (an absorptive dressing) and olling and picking off the black R118's open wound. While	F3	309			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING		1	0/26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, 310 LAKE BOULEVARD BUFFALO, MN 55313		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
F 309	stockinet and gripper allowing R118 to brother dressing change was that time to administ medication (oxycod pain medication) to the medication, apper gripper stocks, and R118 rated her pain dressing change, so because I'm about pain." At 10:43 a.m pack, firmly to her lefter pain as an eight was starting to declask R118 to rate her the dressing change administered PRN puring interview on LPN-F confirmed the indicators she observed R118's dowere aware of these R118's pain managoffering Ultram first was not effective. Lhave ice at any time pain management in time. She was not physician was, for in the pain medicaitor trys to give her (R1) the dressing, so she and "get her bearing when she is ready."	ge 68 er socks were applied, eathe, and rest after the as completed. LPN-F used ster another PRN pain one 5mg 1 tablet, narcotic R118. LPN-F administered blied R118's stockinet and at 10:37 a.m., left the room. as a nine, and during the stated, "It's gotta hit 15, ready to pass out from the ready ready to pass ready to pa	F3	309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	management regi ·Wound treatmen lower extremity- of cover with ABD partial daily and PRN. ·Gabapentin 300 peripheral neurop ·Ultram 50 mg, eventoric pain synd ·Oxycodone 5 mg not relieved by Ulti Review of R118's 8/17/15, to 10/26/R118's New Patie Examination, com (MD)-A and dated osteoarthritis affect hip, with residual arthroplasties. The her pain. On 8/24/15, nurse had complaints of with dressing charcon 9/10/15, NP-A R118's right lower treatments. NP-A will add oxycodon pain." On 9/23/15, a Wo History and Physic the anteromedial leg. This measure [centimeters]. The fibrin and 40% partial and lam unable to it. It does not appear to the stream of the partial leg. This measure [centimeters]. The fibrin and 40% partial lam unable to it. It does not appear to the partial leg. This measure [centimeters]. The fibrin and some partial lam unable to it. It does not appear to the partial leg. This measure [centimeters]. The fibrin and some partial lam unable to it. It does not appear to the partial lam unable to it. It does not appear to the partial lam unable to it. It does not appear to the partial lam unable to it. It does not appear to the partial lam unable to it. It does not appear to the partial lam unable to it. It does not appear to the partial lam unable to it.	ving wound treatment and pain men: t to stasis ulceration on right leanse wound, apply Silversorb, ad and Kerlix, change dressing milligrams (mg), twice daily for athy/ polyneuropathy. Very four hours PRN for pain, for rome. , every four hours PRN for pain tram, for chronic pain syndrome. physician progress notes from 15, identified the following: nt History and Physical pleted by medical doctor 9/3/15, noted she had ching her knees, shoulder and pain post knee and hip the report did not further address the practitioner (NP)-A noted R118 pain to her right lower extremity	F 3	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		1	0/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, 310 LAKE BOULEVARD BUFFALO, MN 55313	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 309	however, the patient with this. My initial is with lodosorb in an but the patient was painful She did rehere and once her then dressed" On 10/8/15, NP-A allower leg ulcer. NP-says, 'I'm ok,' but fruction to Monticello Wounnothing.' She is versallow to be put on Fwaiting for dressing no change to the word continue with antibit through 10/12/15. On 10/19/15, NP-A room visit was revieaddress R118's state. No further assessming an management with progress notes. Review of R118's Endministration Reconstruction and leg particular to the september 20 a total of 103 doses. She took 68 doses effective 42 of 68 of 14 of 68; not effective services.	at developed a lot of discomfort inclination had been to treat it attempt to control drainage afraid that that would be ceive a dose of oxycodone pain got better her wound was addressed R118's chronic right A noted, "Resident today owning and awaiting R [right] dressing [change]. C/o to R LE. Refuses to go back do Clinic- 'They don't know y particular about what she will a LE wound looks unhappy-[change]." The note directed bund treatment and to otic treatment for cellulitis noted R118's emergency ewed. The note did not sis ulcer. Jent, description, or plan for were included in the physician lectronic Medication ord (EMAR) from 9/1/15, to the following as PRN pain dministered for right, lower	F3	09			

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245513	B. WING			10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	R118 had 35 doses September 2015, w 35 opportunities; sl other which was no opportunities. The October 2015 administered 100 dright, lower extremi doses of Ultram 50 of 49 opportunities; and not effective 6 R118 had 51 doses October 2015 which opportunities; slight effective 5 out of 57 identified, 1 out of 58 Review of the EMA from September to correlate with R118 the dressing chang documented. Even though R118 of PRN pain medical approximately 3.7 deach day, along wit 300 mg twice a day	s of PRN oxycodone 5mg in which was effective 14 out of ightly effective 3 out of 35; and it identified 3 out of 35, EMAR identified R118 was oses of pain medication for ty leg pain. She took 49 mg, which was effective 18 out slightly effective 17 out of 49; out of 49 opportunities. To of PRN oxycodone 5mg, in h was effective 34 out of 51 ty effective 11 out of 51; not I and other, which was not		809			
	8/17/15, through 10 of pain for R118: On 8/24/15, at 10:1 "Changed dressing	ursing progress notes from 0/26/15, identified complaints 8 p.m. LPN-G noted, on lower right leg About an had c/o a 'burning pain.'					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10	/26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 309	too much and it ne asked for it to be to dressing cleaned Bacitracin with nor with ABD and wrap not have any further that she receive so that won't burn." On 8/27/15, at 1:05 rates pain 8/10;, 'burns' refused to heing sent to updated doctor]." On 8/27/15, at 10:2 dressing changed. macerated et [and claims the wound swashing wound. Ron her D/T [due to On 9/6/15, at 10:48 c/o pain in RLE or request; cool cloth has been elevated when may have pron 9/7/15, at 1:39 noted, "[R118] refuter that it would steaving it open to a On 9/8/15, 2:28 p. Ithe on call MD/NP resident's wound of to let staff place a orders." On 9/8/15, 11:10 ppain to RLE. [R118] prn pain medicatio call physician sai	ain pill would help or if it was eded to be taken off? Resident aken off. Writer took off I wound and only applied a stick dressing then covered oped with Kerlix. Resident has er c/o pain but is requesting omething else on the wound on the wound of a.m. LPN-D noted, "[R118] over resident alginate dressing have on skin;communication the PMD [primary medical of a.m. LPN-F noted, "Leg of a.m. LPN-D noted, "[R118] of a p.m. LPN-D noted, "[R118] of a p.m. LPN-D noted, "[R118] of applied with some relief; leg of a primary medication." p.m. registered nurse (RN)-C sed to have dressing put on in that thurting again [R118] is	F 30	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 309	[R118] does c/o pair change PRN pair at this time." On 9/19/15, at 1:12 c/o 7/10 pain right is relieved with prn Tr dressing changed to On 9/23/15, 10:39 pmedicated as direct lit burns so bad who On 10/8/15, at 2:09 continues to c/o pair changes et PRN pair when 2 different PF closer together. Re Area on leg measur macerated with sor change when NP w On 10/12/15, 2:27 prontinues to c/o pair Resident makes related continues to be dressing changes." On 10/15/15, at 12: "Treatment comple treatment is being of med prior to tx [treat it hurts when it is op On 10/17/15, at 11: rates RLE pain 7/10 pack and PRN pair During interview on nursing assistant (Ner legs and she had crying." NA-A stated	5 p.m. LPN-B noted, " n during a.m. dressing medication given x [times] 2 a.m. LPN- D noted, "[R118] ower extremity; somewhat amadol, ice, and oxycodone; by DON [director of nursing]." o.m. LPN-I noted, "[R118 was] and for leg pain. [R118] states, and drainage is left on my leg." p.m. LPN-F noted, "[R118] n et request frequent dressing in meds which were helpful and pain meds were given sident has been seen by NP. and the greenish color at first as in room." and LPN-F noted, "[R118] and PRN pain meds given x 2. and pain meds given x 2. and pain meds given x 2. by painful et macerated during and pp.m. LPN-J noted, and the dreceived pain and the properties of the pain while completed, had received pain and pp.m. LPN-D noted, "[R118] and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] and pp.m. LPN-D noted, "[R118] and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] being done. States that and pp.m. LPN-D noted, "[R118] being done.	F3	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10.	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 309	NA-A stated she to R118 complained of see if she could be NA-A stated the pa "somewhat effective [effective]." During interview on registered nurse (Fwas mainly in her ran open area. RN-limproving, but was review of the EMAF rating was typically prior to receipt of hreported R118's ph Thursday and was ensure her pain masufficiently effective notation of the physicommenting on her progress notes, on had attended a wor after 9/23/15, becaudid not want to go to she had spoken to recently as 10/14/1 satisfaction with he Upon inquiry as to pain, RN-H replied that she was aware dressing changes, management regims tated the nature or result in some, ineven changes. However in the country is the state of the same changes.	Id the facility nurses when of and/or appeared in pain, to given any pain medication. in medications seemed e, [but] never 100% 10/26/15, at 2:32 p.m. RN)-H reported R118's pain ight lower leg, where she had H stated the area has been taking a long time. Upon R, RN-H reported R118's pain around an 8 (0-10 pain scale) er PRN pain medications. She ysician was at the facility every responsible for monitoring to anagement regimen was a RN-H stated the most recent sician/ nurse practitioner regimen was the physician's 10/8/15. RN-H reported R118 and clinic, but stopped going use she was very upset and there anymore. RN-H stated R118 about her pain, as 5, and she had indicated regimen management regimen. R118's acceptable level of she was unsure. RN-H stated R118 had significant pain with but believed the current pain nen was effective for her. She f R118's wound was going to vitable pain during dressing, when told of the observed		09		
	leffective]." During interview on registered nurse (F was mainly in her r an open area. RN-limproving, but was review of the EMAF rating was typically prior to receipt of h reported R118's ph Thursday and was ensure her pain masufficiently effective notation of the physicommenting on her progress notes, on had attended a wor after 9/23/15, becaudid not want to go to she had spoken to recently as 10/14/1 satisfaction with her Upon inquiry as to pain, RN-H replied that she was aware dressing changes, management regims stated the nature or result in some, inever changes. However, dressing change of knowledge of R118	a 10/26/15, at 2:32 p.m. RN)-H reported R118's pain ight lower leg, where she had H stated the area has been taking a long time. Upon R, RN-H reported R118's pain around an 8 (0-10 pain scale) er PRN pain medications. She ysician was at the facility every responsible for monitoring to anagement regimen was e. RN-H stated the most recent sician/ nurse practitioner r pain was the physician's 10/8/15. RN-H reported R118 and clinic, but stopped going use she was very upset and here anymore. RN-H stated R118 about her pain, as 5, and she had indicated r pain management regimen. R118's acceptable level of she was unsure. RN-H stated e R118 had significant pain with but believed the current pain men was effective for her. She f R118's wound was going to vitable pain during dressing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245513	B. WING			10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		310	REET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD JFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	she is having that in much pain." RN-H concerns for R118, NAs. RN-H stated, have updated the punmanaged pain, a looked at getting ar medication. RN-H spack was typical, howere seeing, then the management of her R118's pain should confirmed the facilitias their sole pain as completed on a quantification of nursing (completed R118's of frequent basis. She medicated about or change and asked throughout the dress doing. The DON stain a significant amo from sticking to her an ice pack to use for districting her durin DON stated she fell effective as they car R118 was first adm dressing changes withey were presently never seen R118 cr and upon discussio change (10/22/2018).	denied any reports of pain from the facility nurses or she expected staff would hysician if/when they identified increase in R118's pain stated R118's use of the ice owever, "If that was what we hat would not be a sufficient or pain." RN-H confirmed, have been reassessed. RN-H by used section J of the MDS is sessment, which was only	F3	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	changes. The DON discomfort with this if R118 had demons as identified in the expected the nurse medical record and getting some difference. Although R118, had	stated she expected some type of dressing change, but strated significant signs of pain 10/22/15 observation, she is to document this in the see what they could do about ent analgesic medications for	F3	:09			
	had nurses and nur R118 in pain, either or other times durin Gabapentin 300 mg scheduled pain med PRN for pain and o moderate to severe Gabapentin 300 mg in the morning of 10 oxycodone 5mg aft completed. Even th of unmanaged pain distressing pain dur The facility did not of developed an appro	identified significant pain, and sing assistants who observed during her dressing changes g the day. R118 only received g twice a day, for a routine dication, and Ultram 50 mg xycodone 5 mg PRN for pain. R118 only received the g prior to her dressing change 0/22/2015, and then received er the dressing change was ough R118 voiced complaints, and demonstrated ing a wound dressing change. comprehensively assess and priate pain management ist in reducing her pain. This arm for R118.					
	dated 6/14, directed orders to see if a reprior to completion administer any anal. The policy did not furn management during policies regarding p	ng Change, Clean policy I nursing to check physician sident required an analgesic of dressing changes and to gesic medication as ordered. urther address pain g dressing changes. Facility ain management with vere requested, but no					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAKE BOULEVARD BUFFALO, MN 55313	10/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	additional policies of WHEEL CHAIR PC R57's quarterly MD R57 used a wheelc extensive assistance (ADLs). R57's care 4/21/15, indicated slimited range of mo 9/23/15, indicated a increasing weaknest physical and occup A Resident Progress indicated "pillow give due to resident lear Progress Note date up in wheel chair air right." During and observer R57 was sitting in a be sleeping with he arm, leaning to her a.m., R57 was agaic chair, leaning to he 8:58 a.m., R57 was wheel chair with he table. On 10/23/15, observed sitting in 1 right side with her hwas placed on the richair. Although R57 there were no supp support her trunk the During and interview NA-B stated R57 resident and the stated R57 resident.	vere provided.	F3	809			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		COMPLETED		
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE 310 LAKE BOULEVARD BUFFALO, MN 55313	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD O THE APPROPI	BE	(X5) COMPLETION DATE
F 309	During an interview occupational therap R57 was recently gher wheel chair. OT referral "about a mopicked up for ongoi size was appropriat fatigued. During an interview NA-T stated, R57 is get her up for brea in her wheel chair. It to lean a little but he for the past few well buring an interview LPN-H stated, som getting her (R57) to will place a pillow uncomfortable posi that." LPN-H further her second chair, a lateral supports or if at high risk for falling she is always leaning stated, R57 had betherapy for position been re-evaluated. During an interview occupational therap they had received a because of her lear supports. They also	has always leaned to the right hat is." on 10/23/15, at 11:48 a.m., by assistant (OTA)-J stated iven a right lateral support for A-J stated R57 was seen for a conth or so ago," but was not ng therapy. He felt R57's chair e but that (R57) was more on 10/26/15, at 1:53 p.m., a like that "all the time," they kfast and then she falls asleep NA-T further stated, she used er leaning has been going on	F3	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 SS=E	the time of the refer lateral support was amount of assistant and be able to prop OT-K and OTA-J ful leaning that bad who current positioning have been referred evaluation. A policy addressing requested, but was 483.25(a)(3) ADL CODEPENDENT RES A resident who is undaily living receives	of a sore back, and neck. At tral in September 2015, the providing R57 with the ce she needed to sit up right el herself in her wheel chair. Ither stated, R57 was "never en we saw her" and that her was a change and she should back to therapy for an positioning for residents was not provided. ARE PROVIDED FOR	F 31			12/29/15
	by: Based on observate review, the facility for completed for 2 of second end of the completed for 2 of second end of the completed for 2 of second end of the complete for 2 of second end of 2 of 2 of second end of 2 of	ion, interview and document ailed to ensure nail care was residents (R5, R64), bathing residents (R45, R19), and eting was provided for 1 of 5 viewed for activities of daily ho were dependant on staff		F312-E Facility timely submits this responsiplan of correction pursuant to feder state law requirements. This responsion or an agreement that a deficiency of exist or that a statement of a deficiency of was correctly cited or factually base it's not to be construed as an admist against interest of the facility, the administrator, of any employees, agor other individuals who participated drafting or who may be discussed of	ral and onse issions does ency ed and ssion gents d in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
I AKE BII	DGE CARE CENTER	OF BUFFALO			310 LAKE BOULEVARD		
	DGE OANE OENTEN	51 561 ALG		I	BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From page 80 R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, and required extensive assistance from staff to		F 3	312			
					otherwise identified the same. It is the policy of Lake Ridge Care	Center	
	complete her perso	nal hygiene.			to provide the necessary services t maintain good nutrition, grooming a	0	
	was seated in a rec	on 10/20/15, at 9:16 a.m. R5 liner chair in his room. R5			personal and oral hygiene.		
	dark colored substa	ernails on both hands with a ance underneath several of the was diabetic so "not			To assure continued compliance, the following plan has been put into plan		
	everybody can cut t	hem", but added his e to have shorter nails. On			Regarding cited residents: On 22 Oct 15, after Resident 5 refu	ısed,	
	dirty fingernails on I				nurse was able to trim resident's na Resident 5 and Resident 64 nails valudited and were cleaned and trim	vere	
	nursing assistant (N refused cares or as care was to be combath days. At 2:03 nails and stated the clean underneath."	on 10/22/15, at 1:53 p.m. NA)-T stated R5 seldom sistance from staff, and nail upleted on residents scheduled p.m. NA-T observed R5's by were too long, and "not very Further, NA-T stated they my preference of R5 to have s and they should be trimmed.			An interview with resident to obtain preferences completed on Resider and was offered alternative options chux, disposable products etc. Re stated it was his desire to continue newspaper to enhance independer with improved health condition he deel this would be needed any long Resident stated with condition	at 126 s of sident use of nce, but did not	
	licensed practical n long, dirty fingernail cut." Further, LPN- on nursing staff for	10/22/15, at 2:33 p.m. urse (LPN)-A observed R5's s and stated "they need to be A stated R5 was dependent his nail care, and his nails rimmed and cleaned on his			improvement he is now using come at bedside for most all toileting need Resident and NAR Care Guide upon reflect residents preferences for maintaining as much independence possible.	ds. dated to e as	
	registered nurse (R assistance to comp should have been of	on 10/23/15, at 11:23 a.m. N)-A stated R5 required lete his nail care, and his nails eleaned and trimmed, "[They] re of when they get their bath			Resident 19 received their bath on 15. Resident 45 received their bath Oct 15. Resident 19 and Resident be interviewed for bathing preferen 13 Dec 15. 2.Actions taken to identify other po	on 28 45 will ces by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/	26/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
				310 LAKE BOULEVARD			
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 312	Continued From pa	age 81	F 3 ⁻				
	R64 had moderate	OS dated 9/15/15, identified cognitive impairment, and		residents having similar occurr All resident's nails were observensure nails were trimmed.	ved to		
	complete his perso			Random audits on incontinent ensure timely assistance with based on assessed needs.			
	During observation on 10/20/15, at 9:36 a.m. R64 was seated in a standard wheelchair in his room. R64 had visibly long fingernails with several nails having a dark colored substance underneath several nails. R64 stated he preferred to have shorter kept nails adding they "could use a clip." On 10/22/15, at 9:04 a.m. R64 was seated in his			Residents were interviewed us modified CMS Resident QIS Ir to include bathing preferences completed to ensure residents timely bathing.	iterview tool . Audits		
	wheelchair outside have long, dirty find When interviewed	his room, and continued to gernails on both hands. on 10/22/15, at 1:53 p.m.		3.Measures put in place to enside deficient practice does not reconstructed training content included comparisons.	ur: d and lleting		
	assistance to their observed R64's na	ad never refused cares or staff knowledge. At 2:03 p.m. NA-T ils and stated they were "very e cleaned and trimmed.		resident cares (nail care, toilet bathing) and following resident Facility revised process for inte residents about bathing/showe preferences upon admit and w	care plan. erviewing ering		
	observed R64's na	n 10/22/15, at 2:33 p.m. LPN-A ils and stated they should have trimmed on his bath day.		comprehensive RAI reviews. process and procedure for bat review and revised. Care staff Activities educated on change	-acility hing was and		
	stated R64 had no long, dirty fingerna	ew on 10/23/15, at 11:23 a.m. RN-A ad no desired preference to have gernails and they should have been with bathing preferences and honoring Resident Choices by 13 Dec 15.					
	cleaned and trimmed on his bath day. A facility policy on grooming and nail care was requested, but none was provided.			4.Effective implementation of a be monitored by: Facility will complete five audit residents using the modified C Resident Interview Observatio modified CMS QIS Non-Interview	s of MS QIS n or		
	LACK OF BATHIN	G:		Resident Observations and factoring complete five NAR Care Observations	cility will		
	R45's annual MDS	dated 8/11/15, identified R45		weekly for three months. 10 ti			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015	
	PROVIDER OR SUPPLIEF			31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	assistance from since the second stated she does in both because of the further, R45 state consistently make like to have her both facility Lakeside (9/14/15 to 10/21/1 were constructed week, and staff we which day they recompleted. R45's records, however staff initials identified received both record initials were When interviewed NA-C stated R45 they were sometim of staff to complete During interview of staff to complete they was not better they was sometimed to staff to complete they was not better they was some they was not better they was some they was not better they was some they was not better they was not bett	an, and required physical taff to complete her bathing. In 10/22/15, at 1:46 p.m. R45 of always receive her schedule he facility being short staffed. In the facility being short staffed had not receiving her bath as her "angry", and she would athing completed. Dasis Bath Records dated 5 were reviewed. The records by identifying the days of the ere to identify a resident on beived their bath by writing their and initialing next to it when name was identified on the for three weeks there were noticed next to her name to identifying. The spaces provided to be left blank. On 10/22/15, at 1:36 p.m. enjoyed her showers, but added hes not completed due to a lack	F3	:12	for toileting will be completed each for three months. 10 bathing audits be completed monthly for three mo The data collected will be presente Quality Assurance and Assessmen Committee quarterly. At that time to Quality Assurance and Assessmen Committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing is responsicompliance.	s will on the to the		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS A. BUILDING A. BUILDING				E SURVEY IPLETED			
		245513	B. WING			10/	26/2015
_	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD UFFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	stated she was sup a week, but had to because there was facility. Further, R1 receive all of her so important to her. A facility Mill Creek List dated 8/3/15 to scheduled for a bat was constructed by week, and staff we which day they recename on the form a completed. Howev baths for four of six according to the recename have been m staff available to constated her expectat bathing as required. A facility policy on the none was provided LACK OF TIMELY R126's admission of dated 9/25/15, identicognition, required.	proposed to receive a bath twice go without her baths at times "not hear enough" staff at the 19 stated she wanted to cheduled baths as it was "very" Bridge Weekly Bath and Vital 10/21/15, identified R19 was the twice a week. The listing of identifying the days of the re to identify a resident on elived their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their and initialing next to it when received their bath by writing their bath by writing their bath by writing their bath by writing their bath by writin		312			
		ated 10/12/15, identified R126 his elimination related to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		3	STREET ADDRESS, CITY, STATE, ZIP CODE B10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	decreased mobility, bowel. Further, the complete, "Pericare [morning] and HS [I care plan did not id should be complete with those set times. During interview on stated he was depericares after havi however he did not assistance with this stated his bottom with too long, so he would be pan, and place himself to prevent the soiled while he wait pericares. When interviewed on ursing assistant (NR 126 with toileting anoticed feces soiled before. NA-A state using it as a barrier becoming soiled who be panded to have been movement with pericares. A letter submitted process to have a submitted process. A letter submitted process and the process and the process are the submitted process. A letter submitted process and the process are the submitted process. A letter submitted process and the process are the process are the process and the process are the process are the process and the process are the process and the process are the process are th	but remained continent of care plan directed staff to with assist of 1 with am nour of sleep] cares." The entify if or when pericare of for toileting not associcated	F3	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/2	26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	was done." A letter submitted p 10/30/15, authored to use newspaper u told him he didn't ne change linen if it go newspapers under A facility policy on to requested, but none 483.25(d) NO CATE	notifying staff only when he ost survey exit, dated by NA-D noted, "[R126] chose under himself even though I eed to do that and we would t soiled. He continued to put him." pileting and pericare was e was provided. HETER, PREVENT UTI,	F 31			12/29/15	
SS=D	assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder					
	by: Based on observat review, the facility for assess and develop urinary continence reviewed for urinary Findings include:	ion, interview and document ailed to comprehensively interventions to promote for 1 of 3 residents (R64) incontinence.		F315-D Facility timely submits this responsiplan of correction pursuant to feder state law requirements. This responsion and plan of correction are not admit or an agreement that a deficiency of exist or that a statement of a deficiency of the correctly cited or factually based it's not to be construed as an admission.	ral and onse issions does ency ed and		

PRINTED: 12/10/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	10/2	10,1010	
LAKE RI	DGE CARE CENTER	OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 315	9/15/15, identified impairment, require toileting and was, 'R64's Nursing Obsidated 9/18/15, identification in the assessment of a toileting primplemented for R incontinence. R64's care plan day an, "Alteration in expeakness following "Aware of the need the care plan direct request", and, "Mo patterns and reasser request or as need During interview or	R64 had moderate cognitive ed extensive assistance with Always incontinent" of bladder. Servations 3.0 Assessment ntified R64 to be "always dder, and R64 was "not aware to use the toilet appropriately." id not identify if any or what program needed to be 64, to decrease R64's Ited 9/21/15, identified R64 had limination r/t [related to] g hospitalization", but R64 was, if to void/defecate." Further, ted staff to, "Toilet per nitor for changes in elimination ess quarterly and prn [per	F 315	,	ted in the dor		
	the bathroom when but has noticed R6 urine" lately. Furth set toileting schedu. During observation a.m. R64 was assi NA-F removed a v pad from R64, and R64, "Had the wro have had an "extra on during the night skin from being incremoved incontine.	m when he requests as care planned, ced R64 to be "more incontinent of . Further, NA-T was unaware of any schedule for R64. ervation of care on 10/23/15, at 7:24 as assisted to the toilet by NA-F. red a visibly soiled white incontinence 64, and placed it in the trash stating the wrong kind of pad on." R64 should a "extra absorbent" green colored pad enight to help reduce irritation to his eing incontinent. NA-F stated R64's continence pad "was full" of urine, as pically incontinent in the morning, but		are at risk from this deficient practice. Incontinent residents bladder assessments will be reviewed to ensure individualized toileting plans match resident needs with MDSs upon admission, quarterly and with significant changes. 3.Measures put in place to ensure deficient practice does not recur: Facility practices on Care Planning and Toileting were reviewed and revised, as needed, with education provided to licensed staff by 13 Dec 15. Daily IDT meetings were established on 30 Oct 15			

Facility ID: 00714

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	;	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
F 315	when assisted to the Further, NA-F state when he needed to helped him "every to helped him "e	e toilet would sometimes void. d R64 was unable to verbalize use the restroom, so she wo hours" to the restroom. 10/23/15, at 11:34 a.m. N)-A stated R64 was able to se the restroom, "Most of the e helped with toileting every ould not be incontinence of couple times a day," with his the assessment completed on e identified a toileting program continence. essment identified him as " of bladder, and R64 was "not needs to use the toilet ere was no indication if R64 d toileting program, or was a (no attempts to place on the R64 had been using the toilet, e did have some continent urinary incontinence was e was provided. FACCIDENT	F 315	to also aid in capturing residents potentially at risk. MDS's will be completed upon admission, quarte with significant changes, to determ individualized toileting program. 4. Effective implementation of action be monitored by: Facility will complete five NAR Care Observations weekly for three mon Ten chart audits will be done month three months for individualized toile program. The data collected will be presented to the Quality Assessment Assurance Committee quarterly. A time the Quality Assessment & Ass Committee will make the decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing is responsicompliance.	ine the ns will e iths. hly for eting e ent & st that surance g any g to be	12/29/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245513	B. WING		10/2	26/2015
				1 .0	-012010
IDGE CARE CENTER	OF BUFFALO	1	BUFFALO, MN 55313		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
Continued From page	age 88	F 323			
by: Based on observareview, the facility assessed and inte 1 of 1 residents (Rhimself while attembetween his legs a degree burns to hi resulted in immediremained at risk of failed to assess sa implement interverinjuries. The immediate jed 4:50 p.m. when Radegree burns (blist his lower left ankle coffee, and the fac assessment and ir prevent reoccurrer the facility adminis	ation, interview, and document failed to ensure safety was rventions were implemented for 73) who spilled hot coffee on apting to carry the coffee and obtained nine second is lower left extremity. This ate jeopardy for R73, who if serious injury when the facility after with hot beverages and antions to prevent similar appared began on 10/10/15, at 73 obtained nine second tering with partial thickness) to a and foot from the spilled hot beliefly failed to complete an applement interventions to nice. On 10/21/15, at 6:06 p.m. trator and director of nursing		plan of correction pursuant to feder state law requirements. This respond and plan of correction are not admored an agreement that a deficiency exist or that a statement of a deficiency of the facility, the administrator, of any employees, a or other individuals who participated drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care to prevent residents from being but hot beverages. To assure continued compliance, following plan has been put into plants.	eral and onse hissions does iency sed and ission agents ed in the or Center irned by	
(IJ) for R73. The I 8:24 a.m. but none isolated scope and actual harm that is G). Findings include: R73's admission N 10/1/15, identified impairment, requir bed mobility, trans	J was removed at 10/23/15, at compliance remained at an diseverity level, which indicated a not immediate jeopardy (Level Minimum Data Set (MDS) dated the resident had no cognitive ed extensive assistance for fers, locomotion on the unit,		The coffee vending machine was unplugged and has been removed 22 Oct 2015. The coffee vending company has been contacted to rethe coffee vending machine. Residual has been interviewed and has agruse a covered cup when drinking liquids. The resident assessment was reviewed and the care plan was reviewed and the care plan was reviewed on 10/21/15. The Administration and Director of Nursing had a discount with Resident 73 to explore option	emove dent 73 eed to hot for R73 as strator cussion s.	
	PROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR INTERPOLICION OR INTERPOLICIONO OR INTERPOLICION OR INTERPOLICION OR INTERPOLICION OR INTERPOLI	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safety was assessed and interventions were implemented for 1 of 1 residents (R73) who spilled hot coffee on himself while attempting to carry the coffee between his legs and obtained nine second degree burns to his lower left extremity. This resulted in immediate jeopardy for R73, who remained at risk of serious injury when the facility failed to assess safety with hot beverages and implement interventions to prevent similar injuries. The immediate jeopardy began on 10/10/15, at 4:50 p.m. when R73 obtained nine second degree burns (blistering with partial thickness) to his lower left ankle and foot from the spilled hot coffee, and the facility failed to complete an assessment and implement interventions to prevent reoccurrence. On 10/21/15, at 6:06 p.m. the facility administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for R73. The IJ was removed at 10/23/15, at 8:24 a.m. but noncompliance remained at an isolated scope and severity level, which indicated actual harm that is not immediate jeopardy (Level G).	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safety was assessed and interventions were implemented for 1 of 1 residents (R73) who spilled hot coffee on himself while attempting to carry the coffee between his legs and obtained nine second degree burns to his lower left extremity. This resulted in immediate jeopardy for R73, who remained at risk of serious injury when the facility failed to assess safety with hot beverages and implement interventions to prevent similar injuries. The immediate jeopardy began on 10/10/15, at 4:50 p.m. when R73 obtained nine second degree burns (blistering with partial thickness) to his lower left ankle and foot from the spilled hot coffee, and the facility failed to complete an assessment and implement interventions to prevent reoccurrence. On 10/21/15, at 6:06 p.m. the facility administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for R73. The IJ was removed at 10/23/15, at 8:24 a.m. but noncompliance remained at an isolated scope and severity level, which indicated actual harm that is not immediate jeopardy (Level G). Findings include: R73's admission Minimum Data Set (MDS) dated 10/1/15, identified the resident had no cognitive impairment, required extensive assistance for bed mobility, transfers, locomotion on the unit,	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 88 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safety was assessed and interventions were implemented for 1 of 1 residents (R73) who spilled hot coffee on himself while attempting to carry the coffee between his legs and obtained nine second degree burns to his lower left extremity. This resulted in immediate jeopardy for R73, who remained at risk of serious injury when the facility failed to assess safety with hot beverages and implement interventions to prevent similar injuries. The immediate jeopardy began on 10/10/15, at 4.50 p.m. when R73 obtained nine second degree burns (blistering with partial thickness) to his lower left axide and foot from the spilled hot coffee, and the facility administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for R73. The IJ was removed at 10/23/15, at 8.24 a.m. but noncompliance remained at an isolated scope and severity level, which indicated actual harm that is not immediate jeopardy (Level G). Findings include: R73's admission Minimum Data Set (MDS) dated 10/1/15, identified the resident had no cognitive impairment, required extensive assistance for bed mobility, transfers, locomotion on the unit, was reviewed and the care plan w updated on 10/21/15. The Adminis and Director of Nursing had a disc with Resident 73 to explore option.	PROVIDER OR SUPPLIER DGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES (FIGH) AND FEDRAL OR STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 5S313 SUMMARY STATEMENT OF DEFICIENCIES (FIGH) OF DEFICIENCIES (FIGH) OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safety was assessed and interventions were implemented for 1 of 1 residents (R73) who spilled hot coffee on himself while attempting to carry the coffee between his legs and obtained nine second degree burns to his lower left extremity. This resulted in immediate jeopardy for R73, who remained at risk of serious injury when the facility failed to assess safety with hot beverages and implement interventions to prevent similar injuries. The immediate jeopardy began on 10/10/15, at 4:50 p.m. when R73 obtained nine second degree burns (blistering with partial thickness) to his lower left ankle and foot from the spilled hot coffee, and the facility failed to complete an assessment and implement interventions to prevent resocurrence. On 10/21/15, at 6:06 p.m. the facility administrator and director of nursing (DON) were notified of the immediate jeopardy (Level G). Fracility timely submits this response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of a deficiency was correctly cited or factually head in the administrator, of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Lake Ridge Care Center to prevent residents from being burned by hot beverages. To assure continued compliance, the following plan has been put into place; The coffee vending machine. Resident 73 has been interviewed and has agreed to use a covered cup when drinking hot liquids. The resident and biscussed or

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		05 0115541 0		3	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		В	UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323		ns in range of motion, to both	F 3	23	and has agreed to no longer do this will ask for assistance when he won need to transport a hot beverage.		
	10/1/15, indicated weakness from Fri which caused prog system and manife spasticity in lower labsent lower limb inumerous falls at hadmission to the farequired assistance.	ssessment (CAA) dated R73 was at risk for falls due to edrich's Ataxia (a disease ressive damage to the nervous ested as poor coordination, imbs, muscle weakness, and reflexes), with a history of nome, and one fall since acility. The CAA indicated R73 we with transfers, however, a from staff to wait for help.			2.Actions taken to identify other por residents having similar occurrence. The coffee vending machine was unplugged, labeled as out of order was removed from the facility as of 2015. The facility has reviewed all or incident reports for the past 6 moand have noted no other related inj burns of any kind.	and 22 Oct events onths	
	at 4:50 p.m. indicaresident's family mhis wheelchair in the vending machinding area (hillside R73 was holding clost strength, or apfell to the floor out was asked what he the fall, R73 stated out of the vending R73 was alert and had recently receive review indicated enthe fall were hot condition or diagnothe fall. The report to carry hot item in help." The root carresident did not he	tigation Report dated 10/10/15, ted another (unidentified) ember witnessed R73 fall from the facility's lower level, between the sand the rehabilitation eroom). The report indicated offee just prior to the fall, and peared to become weak, and of the wheelchair. When R73 erwas trying to do just before the had gotten a cup of coffee machine. The report indicated orientated, wearing shoes, and the differential factors related to offee and R73's physical erses as contributing factors to a indicated, "Resident is unable [an] unsafe cup. Ask staff for use of the fall identified, eave the strength to hold [an] the cup." The Fall Scene			3.Measures put in place to ensure deficient practice does not recur: The coffee vending machine was unplugged, labeled as out of order was removed from the facility as of 2015. The coffee company Bernick contacted to remove the machine a Oct 2015 to prevent other residents potentially receiving burns from hot disbursed by the machine. The Administrator and Director of Nursia a discussion with Resident 73 to exoptions. Resident 73 has typically hot beverages between his legs in past and has agreed to no longer dand will ask for assistance when he need to transport a hot beverage. 4.Effective implementation of action be monitored by: The Administrator will insure that the coffee machine is removed from the building on 22 Oct 2015. Director of	22 Oct s was as of 21 s from liquids ang had explore carried the to this e would as would	
	Investigation Repo	e cup." The Fall Scene rt did not identify if the resident cated regarding the need for			Nursing, or their designee, will cond and continue to review all incident review.	duct	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 810 LAKE BOULEVARD BUFFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	R73 to be assisted the vending machin assessment of the the ability of R73 to prevent further injure. An Event Details rep.m. indicated, "Respastic as a reaction foot- it is part of his him stiffen to come to the floor. Res. [I facility ad-lib [at wild decisions based or spend leisure time assessed Treatmoustained in this event askin injury on 10/ left foot r/t [related identified multiple this left ankle and the moderate serous of the injury site. Chaindicated blisters, is superficial burns (in epidermis). R73's was identified as, "hand," and poor up a possible contribute The skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the silled as the skin injury dim foot were detailed as the skin injury dim foot were detai	with obtaining coffee out of ne, nor was there an residents wheelchair related to a safely carry the hot coffee to ry. eport dated 10/10/15, at 5:55 as. [R73] states his body went on to the hot coffee pain on his disease process that made a out of his wheelchair and fall R73] is able to get around the l] and make his own a his judgement for how to a Care plan was followed as ment continues to heal the burn vent." alls report dated 10/13/15, and a.m. noted R73 had obtained 10/15, described as, "Blisters to] coffee spill." The report burns to the circumference of the top of his left foot, with trainage and pain present at a racteristics of the skin injury ight redness of skin, and an injury to top layer of skin-activity at the time of injury Fell forward with hot coffee in oper body control was noted as ting factor to the fall/ burn. ensions to the left ankle and as follows: ters (cm) by (x) 2 cm, oval cm, oval cm, circular	F 323	to monitor for any burns for cause for appropriate interventions. Rewill continue to be monitored dadietary and nursing observation employees that are aware of the adaptive equipment to assist the in safely dining in our facility. Rewill also be interviewed at care conferences to determine the neadaptive devices. The need for adaptive devices will be docume the resident chart and will also be on the resident tray card. Resid be interviewed and observed we three months to insure he is ask assistance in transporting hot be Audit results will be presented a Quality Assurance and Assessm committee meeting. 5. Those responsible to maintain compliance will be: The Dietary Manager or designer responsible for maintaining com with adaptive interventions to protential injuries with hot bevera Completion date for certification only is: 22 October 2015	esidents ily through by trained e need of e residents esidents eed for any ented in he listed ent 73 will hekly for hing for everages. It the next hent ee is pliance event ges.	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3	B) DATE SURVEY COMPLETED
		245513	B. WING			10/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP COD 310 LAKE BOULEVARD BUFFALO, MN 55313	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Site 6- 6 cm x 6 cm Site 7- 2 cm x 2 cm Site 8- 3 cm x 2 cm Site 9- 3 cm x 3 cm R73's nursing programmers of the beauty of the site of the back. No injury washowever, when R73'multiple, popped blifound, and redness R73's thighs from the loft of the back. No injury washowever, when R73'multiple, popped blifound, and redness R73's thighs from the lon 10/12/15, at 4:0 physician order had antibiotic medication daily for R73's left fon 10/13/15, at 1:5 blisters to the top or and fluid filled. The and posterior sides On 10/14/15, at 1:2 (RN)-A indicated the burns was changed on the inner ankler most of the blisters Whole foot is swolled freshly popped blist intact at this point. area."	m. licensed practical nurse taff were alerted R73 had elchair. R73 was found lying is body and partially on his sobtained from the fall, 8's wet clothes were removed, sters to the left foot were was also noted to both of ne coffee spill. 1 p.m. LPN-C indicated a loeen obtained for Keflex (an n) 500 milligrams (mg), twice	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10	/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	educated on asking there evidence state ensuring R73 was coffee to prevent further to pre	s no indication R73 was g for staff assistance, nor was ff had been educated on monitored and assisted with urther burns. Ited 10/16/15, identified a in skin integrity related to his ound, ataxia (loss of full vements) and medication use. d, "At risk for skin tears, etc om hot coffee spill 10/15." was for the burn to heal aplications, with interventions ring: Treatments as ordered by and Care Standing Orders were eeded and as appropriate for as needed to moisturize skin, are to be monitored with cares pressure reduction cushion was heelchair, a pressure reduction as the bathing and as needed, and sting was to be done per the nitor for skin risk, with skin risk as needed. The care R73 as at risk for falls related kness, and fall interventions in the risk quarterly and as g for safety and assisting with preventative measures of resheet after use, and physical and as needed. The care as R73's safety with hot ortation of hot beverages, or a risk for burns/injury similar to	F 323				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZI 310 LAKE BOULEVARD BUFFALO, MN 55313	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 323	individualized reside information regardin safety interventions injury, similar to that There was no indicate on the ensure R73 was obtaining coffee out utilizing a safe cup. During interview on director of nursing (R73 had gotten a comachine and spilled from his wheelchair coffee. During observation 9:21 a.m. R73 was was wrapped in gaumultiple burns on his rooffee some and his coffee spilled between his leg, and on his left foot. R73 had severe pain, he better. During this cobserved getting a belongings nearby and the pop can inheld the pop can inheld the pop can inheld the lip of the mouth to the lip of the mouth to the lip of the mouth in the took sips of his process.	he NAs use to know specific, ent care needs), lacked any ng R73's burn, or direction of to minimize the risk for burns/ t which occurred on 10/10/15. Action staff had been educated provided assistance when to five the vending machine and to prevent further burns. 10/20/15, at 9:44 a.m. DON) stated on 10/10/15, offee from the facility vending dicoffee, which led to a fall that as a reaction to the spilled and interview on 10/21/15, at lying in his bed. His left foot uze. R73 stated he had its left foot from spilling coffee. Purchased coffee from the cownstairs in the facility and wheelchair and his wheels ewhat suddenly on the floor, and which he was carrying did the coffee spilt into his boot a stated when it happened he observation, R73 was needle nosed pliers from his and used it to lift the tab of his order to open the can. R73 side a can coozie, and when toop he lifted the beverage up uised his neck to bring his	F3	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		` '	E SURVEY PLETED
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 323	[R73] stated he we vending machine at again.'Business a walk outside for fit to help increase his progress notes since 10/10/15, to indicatint place to ensure burns from the facil. During a follow up in p.m. R73 stated he downstairs prior to at the flavor selection coffee vending machine. It is the flavor selection to try some of the flavor selection coffee out of the comployee told him is completed an unidentified they could help him vending machine as were not allowed to when asked why him coffee purchase, but with retrieving and the stated he had not arrangement. R73 putting his own more getting his own coff machine. During the observed seated in room. His wheelch there were no adaption.	ge 94 note, "When writer asked, ill not be using the coffee one. 'I'm not going to do that Office Manager took [R73] for resh air and sun light in effort mood." There were no other the the coffee burn occurred on any interventions were put the R73 did not obtain further ity coffee vending machine. Interview on 10/21/15, at 3:21 had just recently gone this interview and was looking one offered from the facility thine. R73 stated he wanted avored coffees out of the However, he stated as he was not allowed to get fee machine anymore so he ad again. R73 stated he then are dietary staff downstairs if to purchase a coffee from the not dietary staff downstairs if to purchase a coffee from the not they said no because they handle resident money. The could not have made the ut had the staff simply assist ransporting the coffee for him, of thought of trying that stated he was capable of they into the machine and the out of the vending its interview R73 was his wheelchair in his resident that no arm rests, and tations to the wheelchair to aid ge or any other item. R73 was	F3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	hands and his feet left foot remained with left foot residents had been been told R73 need needed any monitor interventions in place out of the vending remaining room. During interview on (C)-B stated she had coffee vending made been told there were not be using the coshe aware R73 had coffee on 10/10/15. During interview on stated she referred direction on what in interventions were resident, and stated updated daily by the changes in care. Note that the NAs of any residents. NA-B states who had she aware of any significant with left foot many significant with left foot ma	elling his wheelchair with his were on the footrests, and his wrapped in white gauze. 10/21/15, at 3:21 p.m. dietary she was not aware any burned by coffee, and had not ded to be provided assistance, ring, or required any special ce related to obtaining coffee machine located outside the 10/21/15, at 3:21 p.m. cook ad seen R73 using the facility chine in the past. C-B had not re any residents who should affee vending machine, nor was dexperienced burns from the 10/21/15, at 3:28 p.m. NA-B to the NA care sheet for individualized cares and needed for each specific deceived the care sheets were reclinical coordinators with any lA-B stated the nurses also significant changes with atted she was not aware of any received coffee burns, nor was pecial interventions in place for king hot beverages or requiring assistance to obtain coffee	F3	523			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/	26/2015
_	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310 L	ET ADDRESS, CITY, STATE, ZIP CODE AKE BOULEVARD FALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	had been no chang staff provided any ecarrying, obtaining, vending machine. During interview on stated she was awa coffee from the ven burnt himself. NAhim with coffee or his stated she could not she was in rooms to and stated, "He [R7] NA-D stated there in NA care sheets related to R73's burn his confirmed that all the assessments, interrelated to R73's contained the event report of the facility invested to R73's contified of the burns for treatment of the talked to R73 about told her he was, "Nimachine again." The DON stated R73 about told her he was, "Nimachine again." The prevent further in was to speak to him vending machine accare plan was updathappened as a resinterventions had be R73 from burning him the discussion telling him not to us	ge 96 es to his plan of care, nor was education regarding R73 or drinking coffee from the 10/21/15, at 3:41 p.m. NA-D are R73 had purchased a ding machine downstairs and D stated staff were to watch not liquids, however, she of control where he went when aking care of other residents, as nothing specific on R73's ated to coffee or hot liquids. 10/21/15, at 4:07 p.m. DON appened on a weekend, and ne information, reports, ventions, and investigation and information and the information fee burn had been provided, at contained all the information fees burn had been provided, at contained all the information fees burn had been provided, at contained all the information fees burn had been provided, at contained all the information figation and the interventions. The DON stated she at the burn, and the resident ever going to touch that coffee and DON stated the intervention figury from coffee burns for R73 and about not using the coffee gain. The DON stated R73's ated to address the fall that all tof the burn, but no een put into place to prevent imself with coffee again, other she had with the resident are the vending machine again DON stated she was not		23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED			
		245513	B. WING		10	/26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	wanting to purchas vending machine. R73 was downstai office manager (B0 about his placeme aware R73 attemp vending machine. to "go out ad lib" in assessment of R73 "just what I have d report] as a result, added earlier today. During a follow up p.m. R73 stated he supper meals in the stated he did not nutensils or adaptive also stated he, "Sthimself, because hon the chair as it me wheelchair with his wheelchair needed able to move hims. The facility's Wour policy dated 6/14, preventative, intervon the skin and ris resident. The facility's Injury 6/14, directed documents are place. The care place.	se another coffee from the She stated she was aware researlier with the business DM) and had been emotional int at the facility, but was not ted to get coffee from the The DON stated R73 was safe at the facility, and the 3's safety after the burn was ocumented here [on the event as well as the information she at the nursing progress notes. Interview on 10/21/15, at 5:18 at typically ate his lunch and a main dining room. R73 eed to use any modified are equipment for eating. R73 ripped it [wheelchair] all down are did not like having arm rests and at teasier to propel the arms/ hands. R73 stated his at to stay like it was so he was relf around the facility. The Prevention and Treatment directed individualized, wentions be developed based as assessments of each Documentation policy dated amentation of injuries include ontributing factors for the skin and for skin integrity was to be seed based on the resident's	F3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	at 6:06 p.m., was rea.m. when the facilinterventions: - The coffee vendir the facility on 10/22 - R73 agreed to use hot liquids, and the updated to ensure intervention. - If R73 would like thas agreed to ask stransporting it betw. - All residents in the monitored by dietarbeen trained to ensure safety equipment with the necessary adaption of the companion o	pardy that began on 10/21/15, emoved on 10/23/15, at 8:24 ity completed the following and machine was removed from 2/15. The a covered cup when drinking residents care plan was staff was aware of the safety at transport hot beverages he staff for assistance vs een his legs. The building would continue to be ry and nursing staff who had sure resident needing adaptive/were assessed and provided on the equipment to ensure as a many control of the safety of the safety was a many control of the safety of the safety was a many control of the safety of the safe	F3	23			
F 333 SS=D	hot liquids he wished room area. 483.25(m)(2) RESI SIGNIFICANT MEI	D ERRORS Insure that residents are free of	F 3	33		12/29/15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	by: Based on docume facility failed to ens significant medicati (R45) who had a m received the incorrecaused low blood s Findings include: R45's annual Minin 8/11/15, indicated t intact, had diagnos received daily insul Review of the Buffareport dated 4/8/15 instructed by the cli R45 had blood sug milligram/deciliters range 80-120 mg/d Review of the Allina which included phy indicated R45 was acting insulin] as of units in the morning now." The Lake Ridge Ca Order (PO) Report Lantus 37 units sub	NT is not met as evidenced int review and interview, the ure residents were free from on errors for 1 of 1 residents edication error in which they ect dosage of insulin that ugars with physical symptoms. The Data Set (MDS) dated the resident was cognitively es of diabetes mellitus, and in injections. Allo Clinic Telephone order, indicated the facility was inic to notify the physician if ars below 80 (mg/dl), normal blood sugar l. A Health Clinic Buffalo note sician orders dated 4/16/15, to, "Continue Lantus [long in the last dosage which was 37 g. No night time dosage for the Center signed Physician dated 4/20/15, indicated becutaneous once in morning.	F 333	,	ral and onse issions does ency ed and ssion gents d in the or Center any he ace;	
	dose of Lantus. An Allina Health off	ect staff to give a night time ice visit note dated 4/20/15, to go, "Back on lantus 37 units		2.Actions taken to identify other po residents having similar occurrence All residents who receive insulin ar potentially at risk from this deficien	es: e	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245513	B. WING	 	10/2	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	;	STREET ADDRESS, CITY, STATE, ZIP CODE B10 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUSE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 333	at bedtime." Howe R45 had been rece as the resident had units in the morning units more of insuli receiving. The facil increase in insulin Allina physician. Review of R45's Di 4/1/15, to 4/30/15, in the morning. However, and the Lantus 37 units R45's dose of insul Administration Hist received Lantus 37 4/26/15. Review of R45's La Report identified or blood glucose was deciliter). Review of indicate the physici blood sugar, nor diresidents insulin had R45's Resident Profindicated the residents insulin had the low blood sugar the residents insuli 4/20/15. R45's Resident Profindicated the residents insuli 4/20/15.	ver, there was no indication siving Lantus at bedtime prior, I only been taking Lantus 37 g. Although this PO added 37 n, than R45 was currently ity did not clarify the significant R45 was to receive from the abetic Administration History indicated Lantus 37 units once owever, on 4/20/15, Lantus at was implemented, along with in the morning; doubling	F 333	Residents who receive insuling identified and medical provider verified for accuracy against eM 3. Measures put in place to ensideficient practice does not reculticensed staff and HUCs will reeducation on diabetes, transcrimedication orders by 13 Dec 1 procedure for transcription and errors reviewed and revised; or verified by licensed nurse after transcription. 4. Effective implementation of a be monitored by: Five residents who have insulir have MD orders verified agains monthly for three months. The collected will be presented to the Assessment & Assurance Comquarterly. At that time the Qualesses who have the decision/recommend regarding any necessary follow needing to be continued. 5. Those responsible to maintait compliance will be: The Director of Nursing is responsible to maintait compliance. Completion date for certification only is: 29 Dec 15	orders MAR. ure ir: eceive ption and 5. Facility medication ders will be ctions will orders will it eMAR e data ne Quality mittee lity mittee will ation -up audits		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 333	not indicate the phy blood sugar, nor did residents insulin hat R45's Resident Pro 8:33 a.m. indicated sugar) this morning She had a BS of 38 8:44 a.m. and upda A Buffalo Clinic Tele indicated on 4/27/15 called the clinic reg morning of 38 mg/c Communication for Ridge called the clinic patient should actuated time, as the factorders did not mate A Buffalo Clinic Tele 4/27/15, medical dop.m., "Discussed w 4/20/15, visit had w units at bedtime, who daily MORNING DC patient has been redaily since the last sugars." MD-B ord daily in the morning R45's Resident Pro 5:37 p.m. indicated Lantus 37 units BID miscommunication appointment. Spok dose has been d/c'c	rsician was notified of the low of the facility identify the dobeen doubled on 4/20/15. gress Note dated 4/27/15, at and a low BS (blood and a low BS) (blood a low BS) (b	F3	333			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	nursing (DON) state insulin medication of R45, and stated show medication error requires should have they noted the order on 4/20/15, since the that dose before, and current insulin she stated that she had residents orders to problem. DON state training related to the because she was muntil survey on 10/2 error occurred. Although R45 was in morning only, and the order to double 4/20/15, the facility	age 102 2/26/15, at 9:30 a.m. director of ed she was not aware of the error that had occurred for e was unable to locate a port. The DON stated the e called the physician when er for Lantus to be given at HS he resident had not received and the order was doubling the was receiving. The DON not checked any other see if this was reoccurring ted she did not do any staff he significant medication error, not aware the error occurred 26/15, six months after the previously on Lantus 37 units d had a history of low BS after the residents insulin dose on failed to clarify with the onal order of Lantus 37 units	F 33	3		
F 353 SS=F	when R45 had low 4/25/15, and 4/26/1 the physician until 4 insulin dose was do a low blood sugar of symptoms. Also, the looked at other resist prevent other potent 483.30(a) SUFFICI PER CARE PLANS	acility contact the physician blood sugars on 4/22/15, 5. The facility did not contact 4/27/15, 7 days after R45's publed, when the resident had of 38 and experienced ere was no indication they idents, and educated staff to intial medicaiton errors. ENT 24-HR NURSING STAFF Serve sufficient nursing staff to de related services to attain or	F 35	3		12/29/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10/26	5/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	maintain the higher and psychosocial watermined by resign individual plans of the facility must propose the facility maintained in the facility must propose the facili	st practicable physical, mental, vell-being of each resident, as dent assessments and	F 35	3		
	by: Based on observa review, the facility f staffing to ensure r assistance with car reviewed for dignifi residents (R73) rev 5 of the 48 resident R21) reviewed for g residents (R5) revie for 5 of 6 residents R126) reviewed for (ADLs). In addition R55, R85, R118, R 2 of 4 family memb 13 staff members (tion, interview, and document ailed to provide adequate esidents received the required res for 1 of 2 residents (R126) ed care and services, for 1 of 3 riewed for bathing choices, for ts (R27, R19, R45, R35 and group grievances, 1 of 3 ewed for dental hygiene, and (R5, R64, R45, R19, and activities of daily living a for 9 of 9 residents (R126, 5, R73, R35, R123, and R27), wers (FM-G, FM-H), and 13 of NA-G, HK-A, NA-I, NA-C, F, LPN-B, RN-A, OT-K,		F353-F Facility timely submits this responsible plan of correction pursuant to feder state law requirements. This respond plan of correction are not admor an agreement that a deficiency exist or that a statement of a deficiency exist or that a deficiency exist or tha	eral and onse hissions does iency sed and ission agents ed in the or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING		 	10/2	26/2015
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	COTA-J, SM-A and concerns and com staffing. This lack to affect all 48 resi the facility. Findings include: ASSESSED RESIMET: > Refer to F241: Timely assistance of failed to ensure approducts were products wer	d SM-B) interviewed expressed plaints related to insufficient of sufficient staff had potential dents who currently resided in DENT NEEDS NOT BEING The facility failed to ensure with toileting aftercare's and propriate incontinence wided, for 1 of 2 residents assed concerns of undignified The facility failed to honor as for 1 of 3 residents (R73) and choices. The facility failed to ensure to grievances related to This had the potential to affect at (R27, R19, R45, R35 and attended resident council	F3	353	to have sufficient nursing staff to prinursing and related services to attain maintain the highest practicable phimental and psychosocial well-being each resident, as determined by reassessments and individual plans of the continued compliance, the following plan has been put into plans of the correction for F-tags F-241 for R12 F-242 for R73, F-244 for R27, R19 R35, R21, F-282 for R5 and F-312 R64, R44 and R19 relating to the continue of the	in or ysical, of of sident of care. he ice; 6, R45, for are of ndings how exive ilable exited tential es: 5. corate of on 6 open open on 6 open open open open open open open open	

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	RESIDENT CONCE R126's admission dated 9/29/15, ider cognition, and requested to state dhe had to whis call light answer cares. R126 state use the restroom a he never knew how answer his call light "Anxious," and "He interview on 10/26, his preference was toileting and not a response times, he stated, he need he commode, but is uralone, and has to vreported he would commode for toilet because he doesn does not respond timely to help onto use the bedpan an prefers to use. R55's quarterly MER55 had moderate required limited as		F3	353	schedules have been re-created, at posted for two-week time periods of and any vacant positions are posted the schedule. These vacant hours available to current employees, and also called in to a pool agency if the cannot be filled before the pay periodegins. Variably, weekly orientation also been implemented to assist in getting onto the floor. Bonuses have and will continue to be offered to fill vacant shifts, as well as increased differentials. Advertisements for nuand nursing assistants have been a continue to be placed in local paper online sources, such as Indeed, unpositions are filled. Locations that pursing assistant programs have be contacted to let them know of any c	r more, d on are d on are d are ey od as have staff ve been I night urses and will rs and til open provide een open A solicit sing ing to All we are ve are r to er care ed on a ee as will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		05 0115541 0		3	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		В	BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	time to get help to frequently incontine long. R55 stated thelp residents with have the people to R85's quarterly MD had intact cognition assistance from stated the facility had the past two or threatakes, "Quite awhill provide assistance big annoyance." R118's admission I R118 had intact coassistance from stated staffing seen in the evenings. R that needed to be cresident had to wai complete this which become saturated R5's quarterly MDS had intact cognition assistance from states and intact cognition assistance from states.	ad to wait for extend periods of the bathroom, and was ent because of waiting for so the facility needed more staff to their cares, "They just don't work." OS dated 9/1/15, identified R85 in, and required extensive aff to complete ADLs. In 10/20/15, at 10:03 a.m. R85 and been, "Short of staff," for the months. R85 stated staff e" to answer his call light to with cares, and it had, "Been a and MDS dated 8/24/15, identified gnition, and required limited aff to complete ADLs. In 10/21/15, at 11:34 a.m. R118 in ms worst on the weekend and 118 had a dressing change completed, however, the it over 6 hours for staff to he caused the dressing to and drip fluids. In dated 9/15/15, identified R5 in, and required extensive aff to complete ADLs.	F3	353	explanation of how those open posor vacant shifts were covered will be written in the nursing schedule. If a cannot be filled for some reason, the Director of Nursing will be contacted that contact, time and vacancy will written in the nursing schedule bood Director of Nursing will inform the Administrator weekly for two month open nursing department positions shifts unable to be filled and the coaction to fill those positions and shifts an an edded thereafter. All-staff meet will be held monthly for three month Each Employee Quality Improvemed Committee meeting will have adequatefling levels added to the agendate reports continuing to be provided to quarterly Quality Assurance and Assessment Committee, to provide system of allowing employees to distaffing levels to see if they are successful or not; the minutes of those meeting be posted in the employee lounge. Adequate staffing levels will be on agenda for each care conference, attending residents and families be able to comment on whether changes staffing levels are successful or not Reports of adequate staffing will be evaluated and PDSA models will be implemented to continuously improventance staffing. This data collect be presented to the Quality Assess Assurance Committee quarterly meand the QA&A committee will make decision/recommendation regardin necessary follow-up audits needing	e a shift ne d, and be k. The us of and urse of fts, and etings ns. ent uate , with o the scuss scessful gs will the with ing ges with t. e e ed will ment & eeting e the g any	
		n 10/20/15, at 9:11 a.m. R5 id not have enough staff, and			necessary follow-up audits needing continued.	to be	

AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 353	staff would often co staffed to him, and was only one nurse R5 stated his call lig minutes," to get ans	at times R5 had stated there working for an entire shift. ght will take, "Fifteen to twenty swered, and was once left on An hour and a half," before	F 3	353	5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.		
	R73 had intact cognassistance from state During interview on stated he had waite past for staff assist call light to be answover worked and ur to be provided the reactive complete ADLs. During interview on stated the facility stated the facility stated the facility stated to wait to use incontinent due to refrom staff to get to stated the desired to get to stated the facility stated	DS dated 10/1/15, identified nition, and required extensive off to complete ADLs. 10/21/15, at 10:55 a.m. R73 and for nearly two hours in the cance to go to bed and for his pered. R73 stated the staff are not restaffed for the residents necessary cares in the facility. S dated 10/6/15, identified cognitive impairment, and cassistance from staff to 10/20/15, at 10:29 a.m. R35 aff worked short nearly all of had been times R35 would the bathroom but was not receiving timely assistance the restroom. MDS dated 10/15/15, identified gnition, and required extensive off to complete ADLs.					

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING		COMPLETED		
		245513	B. WING _		10	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	,	,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	stated she had wai to the restroom, ca diaper," which she degraded."	ted for over an hour to get help lusing her to, "Just use my stated made her, "Feel	F 3	53		
	R27 had intact cog	OS dated 9/22/15, identified nition, and required extensive aff to complete ADLs.				
	stated she had wai her call light answe	ted for over an hour to have ered to receive assistance, and to have more staff to provide ents needed.				
	During interview or member (FM)-G st family member in the requesting staff assets waited, and waited staff to respond. Toccurrences of waited answered, and FM	NT'S ABOUT STAFFING: 1 10/21/15, at 11:31 a.m. family ated they had visited their he past and used the call light sistance and "Waited, and," over twenty five minutes for here had been multiple ting for the call light to be -G stated, "It [long call light oncerns me." FM-G stated				
	they had been told they were "Adequa disagreed and the staff to help reside. During interview or stated he had notion not being complete at the facility. The	the owners of the facility felt tely staffed," but stated she facility needed to add more				

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10	/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 353	Continued From pa	ge 109	F 35	3				
	STAFF CONCERN	S ABOUT STAFFING:						
	nursing assistant (Ifacility needed more with cares. NA-G secomplain about the and lack of assistant NA-G stated the second in t	10/22/15, at 10:38 a.m. NA)-G stated she felt the e staff to assist the residents stated the residents often long call light response time nce they receive with cares. heduled baths and grooming is not always completed of staffing adding, "[staff] time to take care of the stated several staff had been to care for two assist residents ause, "There's not enough out." NA-G stated the facility staff they, "Are looking into it," provide the resident cares to ang completed.						
	housekeeping aide had been short star had made resident extended periods, a rooms and hear res me." HA-A stated concerns staff is ur	10/22/15, at 10:53 a.m. (HA)-A stated the nursing staff ifed lately. The lack of staff is have to wait for help for and HA-A will often walk by sidents asking, "Help me, help administration is aware of the hable to assist residents with employees they are trying to it it takes time."						
	stated the staffing a and there was freq each hallway to pro The residents frequ	10/22/15, at 1:23 p.m. NA-I at the facility was, "Not good," uently only one or two NA's on vide cares to the residents. uently had to wait, and call wered timely because of the						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245513	B. WING			10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310	EET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD FFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	lack of staffing, "The care they should go members were injushelp for so long, an attempted to roll resolution. During interview on stated the staffing was supposed to he for the residents dust frequently is left with at times on the week nurses and two NA residents, and on the received their schemot made because. During interview on stated the facility we care was suffering instances of only or for residents in the the residents have and attention. NAgrooming of residents in the the administration has a go and talked aboo however, nothing having enough staff been discussed. During interview on stated staffing at the horrible," and residents there was frecovering the Oasis	ey [residents] don't get the et." NA-I stated several staff red because they waited for d nobody came, so they sidents in bed by themselves. 10/22/15, at 1:36 p.m. NA-C was "awful," adding the facility ave six or seven NA's to care ring the morning shift, but h only four NA's. NA-C stated exend there would be just two to care for all of the nat weekend, no residents duled bathing, and beds were	F3	853			

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245513	B. WING	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO		310	REET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD JFFALO, MN 55313	<u>, 10/1</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 353	[staff] don't have tin administration had cares, but "they exp work done and only you guys [state sure. During interview on licensed practical n "Not adequate," to eneeds, and she was facility because she and felt it was being the lack of staffing as a result. During interview on stated she felt the find the staff to provide the and residents had the and families voice for regarding the suffer poor staffing. LPN-dressing changes where the staff to help provide the and residents. During interview on registered nurse (Rallow) and the short of help and the overall. RN-A state because of the pool had never asked the to balance the work staff's input on how situation.	ne," to answer them. The done nothing to help with pect" the floor staff to get the come onto the floor, "When	F3	53				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10	10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 353	therapist assistance could use more hel they hear from resident and waiting, "Way to answered. OT-K a aware of any action address the short so the stand administration the past few days, surveyors] are here home after their shi were unable to complete the residents, "The SM-A stated several recent shift, but only and SM-A was told (DON) to sign the completed. So "Really upset," and with cares on the floonly being done, "but surveyors] are here the surveyors and the surveyors are here the surveyors are here the surveyors are here the surveyors and the surveyors are here the surveyors and the surveyors are here the surveyors and the surveyors are the surveyors are here the surveyors are the surveyors are here the surveyors are the surveyors a	pist (OT)-K and occupational e (OTA)-J stated the floor staff p, and the biggest complaint dents was the lack of staffing oo long for [call] lights," to be and OTA-J stated they were not as being taken by the facility to taffing concerns. The stated they were not as being taken by the facility to taffing concerns. The stated issues were presented at the lack of staff in the facility. The facility was pulling in people to work because you guys [state et al. SM-A stated they often go iff and feel bad because they applete their jobs and care for cares are just not good." The stated them were completed by the director of nursing are sheets identifying they sheets identifying they sheets identifying they have stated administration helping for was not typical, and was because you guys [state et al. SM-B stated, go because of the staffing," and out some shifts with only two et floor to work and care for the	F 3	53			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/:	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		310	REET ADDRESS, CITY, STATE, ZIP CODE D LAKE BOULEVARD JFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 353	documents, which of staff working on the 10/19/15, to 10/23/1 document identified (Oasis, Lake View I Northwoods), and pa staff members na were they were sch. > On the AM shift, 1 no staff names ider work on the unit. In Northwoods each his staff were schedule just one nurse and document identified used to identify staff. > On the AM shift, 1 had no staff names to work on the unit. Northwoods had opnames written in. In one nurse, and one providing care for the identified six of the identified six of the identified six of the identified seven of the identified seven of the identified seven of the identify staff, to be the identify staff, to be the identify staff, to be the identified seven of	Lake Ridge Care Center) displayed the names of the floor for each shift, dated 15, were reviewed. The leach unit of the facility Lane, Mill Creek Bridge, and provided blank spaces in which me was written to identify eduled to work. 0/19/15, the Oasis unit had diffied as being assigned to lill Creek Bridge and ad open spaces identifying no d to work; and were left with one NA for each unit. The lexix of the thirteen spaces f, to be blank. 0/20/15, the Oasis unit again identified as being assigned Mill Creek Bridge and en spaces with no staff both units continued with just NA working on the floor the residents. The document thirteen spaces used to blank. 0/21/15, the Mill Creek Bridge d, only having a nurse care to the residents. e nurse and one NA to e residents. The document the thirteen spaces used to	F3	353				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	((X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE 310 LAKE BOULEVARD BUFFALO, MN 55313	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD E FO THE APPROPRI	_	(X5) DMPLETION DATE
F 353	Creek Bridge and N had one nurse and cares. The docume spaces used to ider > On the AM shift, 1 no staff name ident work on the unit, an have a nurse identifive of the thirteen she blank. On 10/26/15, at 5:0 (DON) stated, "Right staffing. It is the dristated, "We work w resources] all the time staff." The DON acceverything else that quality deficiencies] concerns] There a not be an issue if w floor." The DON stawas well aware of the dand the quality concinsufficient staffing. Staffing shortage be summer when stude there were also eight maternity leave as a facility was still accessitated they had delalater in the week when identified or address.	ge 114 Jorthwoods again each only one NA identified as providing ent identified six of the thirteen ntify staff, to be blank. 0/23/15, the Oasis unit had ified as being assigned to ad the Lake View Lane did not fied. The document identified spaces used to identify staff, to be part of all the other evils. She is corporate HR [human me to get and retain good lded, "I think that almost we've identified [as potential are tied into it [staffing are so many things that would be had enough people on the lated the facility management are facility's staffing shortage beens resulting from DON stated the facility's each around the end of lents returned to college, and the facility staff who had left on well. The DON confirmed the lepting new admissions, but anyed some admissions until laten another resident was asked whether the facility had sed concerns of residents who baths or oral cares, DON	F3				
	staffing we were o	of the things that is tied to doing great until the first or otember We are supposed					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245513	B. WING	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE	
F 356 SS=C	September I think good wash ups." During interview on administrator stated determined based of they, "Have a lot oneeds." The facility down in census, an number of hours diversidents) to determine determined based of they, "Certainly identified amount of dollars." had, "Certainly identified staffing, and the footstaff adding it had bettime." A facility policy on some was provided. 483.30(e) POSTED INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number by the following catunlicensed nursing resident care per sharms.	In [but] have not had one since of everybody is getting really in 10/26/15, at 4:24 p.m. In the facility staffing was on the size of the building, and of residents that have more of does cut hours if they are not uses a formula (total wided by the number of hours per down one bed equals, "X. The administrator stated he notified there is a problem" with cus was to hire and recruit new open the focus, "For a long staffing was requested, but and the actual hours worked begories of licensed and staff directly responsible for hift:	F 3	953		12/29/15	
		as defined under State law). e aides.					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/	10/26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 356	The facility must pospecified above on of each shift. Data o Clear and readable or line and residents and visite. The facility must, unake nurse staffing for review at a cost standard. The facility must must must for review at a cost standard. The facility must must for required by State lateral standard. This REQUIREMED by: Based on observation review, the facility footing was updated start of each shift to working for each shift to working for each shall 48 residents in the working sinclude: During observation Lake Ridge Care Control Directly Responsib was displayed in a the wall by the nursidentified three regulicensed practical massistants (NA) we 10/26/15, during the	ost the nurse staffing data a daily basis at the beginning must be posted as follows: ole format. acce readily accessible to ors. pon oral or written request, g data available to the public mot to exceed the community aintain the posted daily nurse minimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced tion, interview, and document railed to ensure the daily staffed in a timely fashion at the poreflect the actual employees of the facility, staff, and visitors	F 35	F356-C Facility timely submits this responsible plan of correction pursuant to festate law requirements. This results and plan of correction are not according an agreement that a deficiency exist or that a statement of a dewas correctly cited or factually bit's not to be construed as an adagainst interest of the facility, the administrator, of any employees or other individuals who participal drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Catto ensure that the daily posting chours is updated in a timely fash start of each shift.	deral and sponse dmissions by does ficiency ased and mission e, agents ated in the ed or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING _		10/2	26/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 356	"The number of stamay fluctuate." A LRCC (Lake Rid assignment sheet names of the actual The sheet provided to be written with he "Nurse of TMA [traes "LPN/TMA", and "I registered]." The second (RN and LPN), alther three RN's and two working on the floor indicated four NA's Shift 6a [am] - [to] blank spaces left on names being ident During interview of stated the night ship posting and displastation. When the scheduled staff, it the actual staff wo stated, "I don't thin changed." During interview of director of nursing responsible to enscorrect and displaying the shift, the post the actual number "Once its up, I kind posting should be all times, "Because and the states of the st	ge Care Center) daily staff dated 10/26/15, identified the al staff working on the floor. d blank spaces for staff names readings including, "RN", ined medication aide]", NAR [nursing assistant, sheet identified only two nurses rough the posting indicated of LPN's, and three NA's to be or, although the posting so on 10/26/15, during the "Day 6p [pm]." The sheet had seven on the sheet with no staff	F 38	To assure continued comfollowing plan has been p 1. Regarding cited resider Daily staff posting will be timely fashion at the start 2. Actions taken to identify residents having similar or All residents had potential by this deficient practice. 3. Measures put in place to deficient practice does not Education was provided to addressing the componer deficiency related to the phours, and policy for postinours will be reviewed an include procedure for upon staffing changes by 13 Definition of Nursing, or will audit posting of staffing weekly basis for three monocollected will be presented assessment & Assurance meeting, quarterly, and at QA&A committee will make decision/recommendation necessary follow-up audit continued. 5. Those responsible to monompliance will be: The Director of Nursing is compliance.	ut into place; Ints: updated in a of each shift. If other potential ccurrences: I to be affected I to be affected I to ensure t recur: I to staff Ints of this I to staffing I to staffing I to revised to I to actions will I to their designee, I to the Quality I		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING	B. WING		26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 356 F 371 SS=E	displayed, "Daily by nurse currently in c However, the policy procedure for ensu actual staff working 483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food froconsidered satisfac authorities; and	the posting is completed and the Clinical Coordinator or the harge of the department." I lacked a process or ring it is updated to reflect each shift. COURE, SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food	F3	Completion date for certification ponly is: 29 Dec 15	ourposes	12/29/15
	by: Based on observatoreview, the facility for stored in a safe macross contamination refrigerators observed had potential to affect ould have consumfoods that was under the findings include: During the initial too 10/19/15, at 6:21 p. refrigerator was operfidge had 4 shelves	NT is not met as evidenced ion, interview, and document ailed to ensure raw meat was nner to reduce the risk of n to other foods in 1 of 2 yed in the main kitchen. This ext 15 of 15 residents who led the potentially affected er the raw product. Our of the facility kitchen on m. a Norlake Advantage ened and inspected. The s, and sitting on the top shelf iner which contained a single,		F371-E Facility timely submits this respondence of correction pursuant to fed state law requirements. This result and plan of correction are not addornously an agreement that a deficiency exist or that a statement of a defi was correctly cited or factually bait's not to be construed as an addingainst interest of the facility, the administrator, of any employees, or other individuals who participal drafting or who may be discussed otherwise identified the same. It is the policy of Lake Ridge Care	eral and conse missions does ciency sed and nission agents ted in the	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/:	26/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
		05 BUSEAL 0		310 LAKE BOULEVARD			
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 371	Continued From page	age 119	F 371	1			
	labeled, "CHX [chi	n breast. The container was cken] BREAST - RAW - 10/17," ible light pink colored juices on		to ensure raw meat is stored in a manner to reduce cross contami			
	the bottom of the o	container. The shelves below ained several other food items		To assure continued compliance following plan has been put into			
	approximately ten vegetables, and a	ray which contained non-sealed, bagged raw plastic container without a lid of non-sealed, bagged servings		Regarding cited residents: The Dietary Manager immediate the covered/sealed pan of raw chicken/turkey to the bottom she	lf upon		
	10/21/15, at 9:11 a container with raw	n of meal preparation on a.m. (two days later) the plastic chicken remained in the		surveyor notification of finding or 15. This action was taken per su recommendation.	rveyor's		
	there was now an raw turkey burger "T. Burgers 10/15 non-sealed, bagge	or on the top shelf. However, additional plastic container of patties on the top shelf labeled, and 10/18". The plastic tray of ed vegetables and Spanish rice ath of the containers of raw		2.Actions taken to identify other presidents having similar occurrer All residents served out of the mixthen had the potential to be at the issue cited in the statement of deficiencies.	nces: ain fected by		
	During interview of (CK)-A stated raw the top shelf becauspills, it would constated raw meat, "[shelf]." CK-A stat	n 10/21/15, at 9:48 a.m. cook meats should not be stored on use if the container leaks or taminate the other foods, and Should be on the bottom ed she received training when work in the kitchen that, "Meat		3.Measures put in place to ensure deficient practice does not recurs. Refrigerator and Freezer Storage was changed to reflect that all rawill be stored on bottom shelving 15. The Dietary Manager began educating the Dietary staff on the surveyor's recommendations to raw meats on the bottom shelving immediately. All Dietary employers	e policy w meats 27 Oct e store all		
	certified dietary ma meats should be s refrigerator and, "I should be stored of the containers of ra knocked over, it co	n 10/21/15, at 10:38 a.m. anager (CDM) stated raw tored on the bottom of the Technically anything that's raw on the bottom." CDM stated if aw meats were to leak or be buld cause spillage onto the in the refrigerator.		educated by 11 Nov 15. 4.Effective implementation of act be monitored by: The Dietary Manager, or designe audit the storage of raw meat in refrigerators to insure safe practifollowed. Audits will be done week	tions will ee, will the ces are		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412 SS=D	corporate registere stated raw meat sh bottom shelf," becas spilled it could cont vegetables and Spart RD-A stated raw ch potentially contain illness if the juices. The facility Refriger policy dated 11/10/raw items are thaw refrigerator so that onto other foods a manner to prever contaminating othe 483.55(b) ROUTIN SERVICES IN NFS The nursing facility an outside resource §483.75(h) of this provered under the dental services to resident; must, if ne making appointment transportation to ar must promptly referdamaged dentures This REQUIREMED by: Based on observar review, the facility for the state of the	10/22/15, at 3:07 p.m. d dieticians (RD)-A and RD-B ould be placed, "Ideally on a use if it was knocked over or aminate the bagged anish rice stored below it. licken and turkey could bacteria and cause food borne were spilled onto other foods. Tator and Freezer Storage 14, identified, "Meats or other ed in the bottom of the melting liquids do not drop All food items will be stored in at drippings from r items below." E/EMERGENCY DENTAL must provide or obtain from e, in accordance with part, routine (to the extent State plan); and emergency neet the needs of each excessary, assist the resident in this; and by arranging for and from the dentist's office; and or residents with lost or	F 412	one month and then quarterly for simonths. 5. Those responsible to maintain compliance will be: The Dietary Manager is responsible the overall compliance. Completion date for certification puronly is: November 11, 2015	e for rposes	12/29/15

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING	NG 10/:		10/2	26/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		В	BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	manner for 1 for 3 dental hygiene and Findings include: R85's quarterly Min 9/1/15, identified Finding observation R85 was seated in had visible missing his upper denture spoke. R85 stated "Worn down", and R85 stated at time because of the loo like to have them I	residents (R85) reviewed for d who needed new dentures. nimum Data Set (MDS) dated R85 had intact cognition. n on 10/20/15, at 10:10 a.m. his room in a wheelchair. R85 g teeth on his lower palate, and moved in his mouth while he d his dentures were getting, were, "Not effective anymore." s he had trouble chewing food se fitting dentures, and would ooked at by a dentist.	F 4	112	state law requirements. This respo and plan of correction are not admis or an agreement that a deficiency d exist or that a statement of a deficiency was correctly cited or factually base it's not to be construed as an admis against interest of the facility, the administrator, of any employees, ago or other individuals who participated drafting or who may be discussed of otherwise identified the same. It is the policy of Lake Ridge Care of to ensure dental recommendations acted upon in a timely manner. To assure continued compliance, the following plan has been put into plan	ssions oes ency ed and esion gents d in the er Center are	
	identified R85 had visits the facility. I [patient] has full up partial denture is no remaining lower te gumline Both fur extreme occlusial on both for retention upper only" The plan of, "Will tx [treelower dentures and can refer to an orangemaining lower te R85's facility progridentified R85, " vecommends that lower roots extract then have a new further series."	press Notes dated 8/11/15, been seen by the dentist who he dentist identified, "Pt oper and lower partial. Lower of anchored on any teeth as all eth are fractured off at the ll upper and lower partial have wear, and pt it using adhesive on. Pt is interested in new edentist identified a treatment eat] plan full upper and full d if pt decides to proceed, we I surgeon for the extractions of eth [roots]." The ess notes dated 8/11/15, was seen by In House Dental resident has all remaining red with an oral surgeon & [and] all upper and lower denture as these recommendations with			1. Regarding cited residents: Resident is alert and orientated. Resigned consent form for facility dent vendor but then chose to go to outs dentist. Social Worker met with Re 412 to review resident preference for dentures on 26 Oct 15, and an oral consult was completed on 3 Nov 15 Appointment is scheduled with the surgeon to proceed with the denture process. 2. Actions taken to identify other pot residents having similar occurrence Medical records or designee review dental visit log to ensure residents we pending dental needs have follow upon in place. Modified Resident QIS Int questionnaire was asked of resident ensure dental needs are met according.	tal ide sident or 5. oral e ential es: red with p plan erview ts to	

245513 B. WING	10/2	
		26/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZI	P CODE	
LAKE RIDGE CARE CENTER OF BUFFALO		
BUFFALO, MN 55313		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF OUT OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT OF CROSS-REFERENCED TO TOTAL OUT OF CROSS-REFERENCED TO TOTAL OUT	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 412 Continued From page 122 F 412		
resident and if he chooses will send him out to a consult to pursue" No further notes were		
identified in R85's medical record as having the follow up completed for new dentures as deficient practice does not be a second that dentities are desirable and the dentities are desirable	ot recur:	
requested by R85 and the dentist. Due to dental vendor not meet resident needs with	in facility, facility	
During interview on 10/26/15, at 10:05 a.m. was in transition to a new registered nurse (RN)-A stated she wasn't aware during survey. Facility has		
registered nurse (RN)-A stated she wasn't aware of the dental recommendation for R85 to have a IDT stand up meetings st		
dental consult, and stated the facility social to monitor for potential de		
worker should have followed up on the consult MDS Coordinator for the	facility will ask	
and concerns with R85. oral care questions with F		
contact social worker or o		
During interview on 10/26/15, at 10:22 a.m. needs are required or reculicensed social worker (LSW)-A stated she was education will be provided		
aware R85 had been requesting new dentures be completed by 13 Dec		
since "he came" (admitted to the facility), but LSW-A stated she was not aware of the 4.Effective implementation	on of actions will	
recommendations by the dentist on 8/11/15, for be monitored by:	or actions will	
R85 to be seen by an oral surgeon. LSW-A Dental logs will be review	ed monthly by	
stated any follow up completed would have been medical records or design		
documented in the progress notes, and she was to ensure timely dental for		
unable to locate any documentation it had been completed. Facility will condition of recidents using		
addressed. audits of residents using CMS QIS Resident Interv		
During a follow up interview on 10/26/15, at 11:21 or modified CMS QIS No		
a.m. LSW-A stated she had just spoken to R85 Resident Observations at		
and he would like to pursue getting new dentures complete five NAR Care	Observations	
made, so LSW-A stated she would assist the weekly for three months.		
resident to make a dental appointment. collected will be presente		
Assessment & Assurance A facility policy on dental consultation was quarterly meeting. At that		
requested, but none was provided. requested, but none was provided. requested to request the committee will make the	II IIIIe IIIe QAQA	
decision/recommendation	n regarding any	
necessary follow-up audi		
continued.		
5.Those responsible to m compliance will be:	naintain	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING		10/26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO	3	STREET ADDRESS, CITY, STATE, ZIP CODE 810 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412	Continued From pa	ge 123	F 412	The Director of Nursing is responsible compliance. Completion date for certification pur		
F 428 SS=D	483.60(c) DRUG R IRREGULAR, ACT	EGIMEN REVIEW, REPORT ON	F 428	only is: 29 Dec 15		12/29/15
	reviewed at least or pharmacist. The pharmacist muthe attending physic	of each resident must be note a month by a licensed ast report any irregularities to cian, and the director of reports must be acted upon.				
	by: Based on interview facility failed to ens recommendations to parameters for use residents (R5) review medication use. Findings include: R5's quarterly Mining 9/15/15, identified Fipain, and required activities of daily lividentified R5 had diosteomyelitis [an in	AT is not met as evidenced and document review, the ure the consultant pharmacist to establish pain medication were acted upon for 1 of 5 ewed for unnecessary mum Data Set (MDS) dated R5 had intact cognition, no extensive assistance with his ings (ADLs). The MDS agnoses including chronic fection of the bone or bone pressure related foot ulcer.		F428-D Facility timely submits this response plan of correction pursuant to federa state law requirements. This respondent plan of correction are not admissor an agreement that a deficiency dexist or that a statement of a deficiency of the factually base it's not to be construed as an admistagainst interest of the facility, the administrator, of any employees, agor other individuals who participated drafting or who may be discussed of otherwise identified the same. It is the policy of Lake Ridge Care Care	al and nse ssions oes ency d and sion gents d in the r	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245513	B. WING			10/26/2015	
	PROVIDER OR SUPPLIER			31	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	10/6/15, identified including the follow "Acetaminophen [rand inflammation] DX: [diagnosis] paneeded]." "Tramadol [narcoti IV [four] tablet; 50 The signed physic identify any param nursing staff shoul Acetaminophen vecontrol R5's pain. R5's Consultant Pl Reviews directed transignificant problestaff: 8/3/15 - " [#5] Pleat parameters for usi [versus] Tramadol 9/2/15 - "Repeat Mareview] 8/3/15 #5 - 10/1/15 - "Repeat Appear to be addressed appear to be addressed R5's medical recomno evidence the correcommendations on 8/3/15, 9/2/15, clarifying the parameters included the parameters in the parameters of the correct of the correct of the correct of the parameters in the par	cian Order Report dated medication orders for pain ving: medication used to treat pain tablet; 650 mg [milligrams] in Every 4 Hours - PRN [as c-like pain reliever] - Schedule mg; Every 6 Hours - PRN." ian orders did not provide or eters or direction for when dadminister the ersus the Tramadol to help enarmacy Drug Regimen the following, "Potential by [sic] em," to be acted upon by facility ese check if there are ng prn Acetaminophen vs?" IMR [medication regimen if not addressed." 8/3/15, MMR #5. Does not	F 4	28	to ensure that pharmacist recommendations to establish pain medication parameters for use are upon. To assure continued compliance, the following plan has been put into planta. Regarding cited residents: The cited resident is alert and orient and was interviewed on 30 Oct 201 Resident requested that he be allow continue to request Tylenol as need general discomfort and indicated he longer wanted Tramadol. The pharmace medical provider contacted to discommendation was reviewed and medical provider contacted to discommendation and the pharmacy recommendations for past quarter were reviewed by 29 December 2015 to ensure follow up on pharmace recommendations. Issues noted do the review were corrected for compositions. Issues noted do the review were corrected for compositions and pharmacy recommendations will be distributed by Director of Nursing to designated nurses for completion. Education was provided on this definant Pharmacy Medication Regimer Reviews that was completed 13 Dewith licensed staff. Education on Medication Administration was comby 13 Dec 2015 for licensed staff and	acted ne ce; tated, 5. ved to ded for e no macist destruction time of the lestruction the lestruction time of the lestructi	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		E CONSTRUCTION		SURVEY PLETED
		245513	B. WING	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 SS=D	provide either of the how much pain he wishe stated establish staff were treating in reviewed R5's EMA administration reconstablished parameters and update pharmacy recommendation by parameters for R5's medical record recommendation by parameters for R5's was not addressed recommendations on, "That's an issue During interview on consulting pharmacy facilities a certain this recommendation should have address made on 8/3/15, 9/2 "It should be done." A facility policy on management was reprovided. 483.65 INFECTION SPREAD, LINENS	urse (LPN)-A stated she would a medications to R5 based on would complain of, however, ned parameters would ensure R5's pain consistently. LPN-A R (electronic medical rd) and stated there were no eters for R5's as needed pain and stated the nursing staff acists recommendations after the physician with the endations. RN-A reviewed and stated the replacementations and stated the resoluted have been followed up and stated the should have been followed up and stated the recommendations and stated the should have been followed up and stated the recommendations and stated, and 10/1/15, and stated, and 10/1/15, and stated, and the recommendations are period for regimen review and requested, but none was a CONTROL, PREVENT	F 4		TMAs. 4.Effective implementation of action be monitored by: Audits will be completed on 10 reside with pharmacy recommendations of to ensure timely follow up for three months by the Director of Nursing, designee. The data collected will be presented to the Quality Assessmentation Assurance Committee quarterly. At time the QA&A committee will make decision/recommendation regarding necessary follow-up audits needing continued. 5.Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance. Completion date for certification puronly is: 29 Dec 2015	dents nonthly or their e nt & t that e the g any to be	12/29/15
		tablish and maintain an ogram designed to provide a					

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
		245513	B. WING		10	/26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP 310 LAKE BOULEVARD BUFFALO, MN 55313		. 20.10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	to help prevent the of disease and infer of disease and infer (a) Infection Contro. The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pushould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility mush ands after each din hand washing is incorposed professional practicular (c) Linens Personnel must had transport linens so infection. This REQUIREMENT by: Based on observations and infection of the control of the c	comfortable environment and development and transmission oction. I Program tablish an Infection Control och it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections. The add of Infection ion Control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 4	F441-D Facility timely submits this		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE DI	DOE 04DE 05NTED	OF BUFFAL O		310	0 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO		Вι	JFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 127	F 4	41			
	spread of infection	nd procedures to prevent the for 1 of 3 residents (R118) wound dressing change.			plan of correction pursuant to feder state law requirements. This respo and plan of correction are not admi- or an agreement that a deficiency of exist or that a statement of a deficie	nse ssions loes	
	_				was correctly cited or factually base	ed and	
		esident Admission Record			it's not to be construed as an admis	ssion	
	identified diagnoses including cellulitis of the right lower extremity, non-pressure chronic ulcer of				against interest of the facility, the administrator, of any employees, ag	nonto	
		unspecified severity-			or other individuals who participated		
	non-healing, and pseudomonas in wound. R118's admission Minimum Data Set (MDS) dated 8/24/15, identified R118's cognition was				drafting or who may be discussed of otherwise identified the same.		
					It is the policy of Lake Ridge Care (Center	
		limited assistance for most			to maintain an Infection Control pro		
	activities of daily liv				designed to provide a safe, sanitary comfortable environment and to he	and	
		:16 a.m. licensed practical			prevent the development and	•	
		s observed completing a DR118's open wound to the			transmission of disease and infection	on.	
		N-F gathered the necessary			To assure continued compliance, th		
		an towel directly on the floor			following plan has been put into pla	.ce;	
		ht foot, while R118 remained elchair. No barrier was placed			Regarding cited residents:		
		and the floor. After washing			Nurse completing the wound care is	s no	
		lying gloves, LPN-F removed			longer employed by facility.		
		t (a stretchy fabric used for red the soiled dressing with use			2.Actions taken to identify other pot	ential	
		, and then removed the			residents having similar occurrence		
		er the open wound to R118's			Residents requiring dressing change		
		e dressing and absorption pad			wound care have the potential to be		
	were discarded in	the trash, but the stockinet and			affected by area cited.		
		aside, while LPN-F proceeded			2 Magauras put in place to ansura		
		ne Wound Wash to soak and o (antimicrobial wound			3. Measures put in place to ensure deficient practice does not recur:		
		18's open wound. Dark brown			Education on Infection Prevention a	and	
		was observed to break free			revisions completed with licensed s		
	from the wound an	d drip onto the towel beneath			13 Dec 15. Education content used		
	R118's foot. LPN-I	F removed the dark brown			facility orientation and with annual		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/26/2015		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	OF BUFFALO			10 LAKE BOULEVARD SUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	wash to break it up wash, mixed with of from R118's right to towel was visibly sarea beneath R118 inches in diameter removed her glove cleansing the woun applied new dressi the wound, then pl footrest of her whe inward and draped She picked up her behind R118, next rested the scissors covered the top of was placed between mat. She then read stand drawers. At ther wheelchair for so LPN-F could op her supplies. The r R118's wheelchair area of the floor the soaked towel. Once accessing the night self-propelled her was and area and ret At 10:37 a.m., LPN disinfectant wipe froat and wiped the towel was placed, sanitizing wipe from the scissors clean stand drawers. LPI mat where she had R118's night stand	he wound using the saline and removed it. The saline debris/ slough, was dripping ower leg, onto the towel. The oaked through, in a circular 3's right heel, approximately six. At 10:27 a.m., LPN-F and washed her hands after and. At 10:29 a.m., LPN-F and a clean stockinet to aced R118's foot back onto the elchair. LPN-F folded the towel it over the lined garbage bin. supplies and stepped back to the night stand. LPN-F at atop a Dycem mat, which R118's night stand. No barrier on the scissors and the Dycem ched to open one of the night this time, R118 self-propelled ward approximately 18 inches, aren the drawers and put away right front and back wheels of was observed to roll over the at became soiled by the e LPN-F had finished at stand drawers, R118 wheelchair back through the urned to her original position. I-F retrieved a Clorox om her medication/treatment flooring beneath where the then obtained another in her cart and returned to wipe and return it to one of the night N-F did not wipe the Dycem of rested the soiled scissors on LPN-F stepped away from riginal (soiled) stockinet which	F4	.41	in-services related to Infection Prevereviewed and revised by 29 Dec 15. 4. Effective implementation of actions be monitored by: Monitor a random sampling of reside with dressing change treatments five times per month for three months. It data collected on these audits will be presented to the Quality Assessment Assurance Committee quarterly. At time the QA&A committee will make decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Infection Control Coordinator for facility will be responsible for compliance of the completion date for certification purponly is: 29 Dec 15	ents e The e that ethe gany to be or the fance.		

AND DUAN OF CODDECTION DENTIFICATION NUMBER.) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10	/26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	thin metal bar of F behind the right for wheel. The stockin circular, light to dardrainage. During interview or LPN-F stated it wa towel directly on the that drip to the floodressing changes. Clorox disinfectant the floor after the coshe did not realize through the soiled disinfected it. LF cleaning up the supstockinet from the and it was R118's postockinet and re-us through the laundry about placing the solvent placing the solvent placing the solvent place of the clean dressings and LPN-F stated she to where she had set wipe. During interview or	age 129 e earlier, was draped over a tall8's wheelchair, located of rest, near the right front et was observed with multiple, the brown spots of dried wound in 10/22/15, at 10:51 a.m. Is her typical practice to use a efloor to, "Sop up any fluids r," during R118's wound LPN-F stated she used a wipe to clean the surface of dressing change. LPN-F stated R118 propelled her wheelchair area of the floor before she end of the soiled linens she had gathered, oreference to rinse out her see them, rather than send them by When LPN-F was asked coiled scissors on top of the 8's night stand, she stated, "[I] where" LPN-F stated she ep the scissors apart from her d to keep it off of the floor, and thought she had wiped the area the scissors with a sanitizing in 10/26/15, at 2:24 p.m. RN)-B, the facility's infection	F 4-	,		
	control coordinator sanitizing wipes sh supplies LPN-F ga change. RN-B state beneath the towel,	, stated disinfectant and ould have been amongst the thered for R118's dressing ed without a proper barrier LPN-F should have disinfected iately, and if the wheelchair did				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
245513 B. WING	10/26/2015
LAKE RIDGE CARE CENTER OF BUEFALO	DDRESS, CITY, STATE, ZIP CODE BOULEVARD O, MN 55313
	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE IOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
	0-F ty timely submits this response and of correction pursuant to federal and

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245513	B. WING	· · · · · · · · · · · · · · · · · · ·	10/2	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 490	0 0 11111111111111111111111111111111111	age 131 cation survey. This had	F 490	and plan of correction are not ad	miccione		
	potential to affect a facility.	all 48 residents residing in the		or an agreement that a deficienc exist or that a statement of a def was correctly cited or factually ba	y does iciency ased and		
	Findings include:			it's not to be construed as an adragainst interest of the facility, the)		
> Refer to F353; The facility failed to padequate staffing to ensure residents the required assistance for 1 of 2 resi (R126) reviewed for dignified care and for 1 of 3 residents (R73) reviewed for		o ensure residents received ance for 1 of 2 residents or dignified care and services,		administrator, of any employees, or other individuals who participa drafting or who may be discusse otherwise identified the same.	ted in the		
	choices, for 5 of th R35 and R21) reviol 1 of 4 residents (R ulcers, for 1 of 3 re dental hygiene, an	for 5 of the 48 residents (R27, R19, R45, R21) reviewed for group grievances, for idents (R126) reviewed for pressure r 1 of 3 residents (R5) reviewed for giene, and for 5 of 6 residents (R5, R19, and R126) reviewed for activities		It is the policy of Lake Ridge Car to administer the facility in a mar enables it to use its resources ef and efficiently to attain or mainta highest practicable physical, mer psychosocial well-being of each	iner that fectively in the ntal and		
	residents (R126, R R123, and R27), 2	s). In addition, for 9 of 9 55, R85, R118, R5, R73, R35, of 4 family members (FM-G, 3 staff members (NA-G, HK-A,		To assure continued compliance following plan has been put into			
	NA-I, NA-C, NA-T, OT-K, COTA-J, SN expressed concerr insufficient staffing	-I, NA-C, NA-T, NA-K, LPN-F, LPN-B, RN-A, -K, COTA-J, SM-A and SM-B) interviewed who pressed concerns and complaints related to ufficient staffing. This lack of sufficient staff d potential to affect all 48 residents, staff and		Regarding cited residents: Facility Administration met with c HR to develop a staffing action p Nov 15. Facility has developed a implemented action plans for cite deficiencies related to the care a services of residents (Refer to F)	lan on 6 and ed nd		
	nursing assistant (I facility needed mor with cares. NA-G	n 10/22/15, at 10:38 a.m. NA)-G stated she felt the re staff to assist the residents stated the residents often		Quality Assessment and Assurar Committee will meet in January t and revise action plans.	o review		
	and lack of assista NA-G stated the so (nail care, shaving)	e long call light response time nce they receive with cares. cheduled baths and grooming is not always completed k of staffing adding, "[staff]		 Actions taken to identify other presidents having similar occurrer All residents had the potential to affected. 	nces:		
	don't have enough	time to take care of the stated several staff had been		3.Measures put in place to ensur deficient practice does not recur:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING	B. WING			26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	by themselves bed staff on to help us administration tells but rarely help state ensure they are be administration reviresponsibility. During interview on housekeeping aided had been short state had made resident extended periods, rooms and hear reme." HA-A stated concerns staff is uncares, but they tell add more staff, "But During interview on stated the facility work care was suffering instances of only off or residents in the the residents have and attention. Nat grooming of residents in the the residents have and attention. Nat grooming of residents in the the residents have and attention. Nat grooming of residents in the the residents have and attention. Nat grooming of residents in the the residents have and attention held with all staff and tastaffing, however, improve the lack of can be completed followed up regard the needs of the residents.	to care for two assist residents cause, "There's not enough out." NA-G stated the facility is staff they, "Are looking into it," if provide the resident cares to eing completed, nor have the ised delegations or staff in 10/22/15, at 10:53 a.m. in 10/22/15, at 10:5	F 4	190	Facility has added a QAPI meeting conducted between the quarterly Quassessment and Assurance Commmeetings. Action plans will be deveral as needed for indicated quality needed identified at QAPI. Quality Assessment and Assurance Committee will detecompliance regarding action plan and IDT was educated on QIS Quality Assessment and Assurance Command Staff was educated on the role Quality Assessment and Assurance Committee by 13 Dec 2015. 4. Effective implementation of action be monitored by: Administrator and Quality Assurance Assessment Committee will monitor action plans and report to corporate assistance in oversight. Action plan be monitored for progress towards and revised as needed. Quality Assurance and Assessment Commwill determine compliance regarding action plan areas. Administrator wupdates on action plan implementat Resident Council and staff meetings for three months. Elim COO, or des will monitor Administrators performs monthly for three months to ensure administration has been acting on the concerns identified by staff and residence of the compliance will be: Corporate COO or designee is responsible for compliance.	uality ittee eloped ds as nent rmine reas. ittee of swill e and reforms will goals ittee givill give tion at stimes signee, ance nese	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING _		10	/26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313		720,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 490	horrible," and reside stated there was frovering the Oasis and residents had to get their call light [staff] don't have the administration had cares, but they experienced work done and onliguys [state surveyor During interview or registered nurse (Fa "big issue" at the short of help and the staffing, and admirstaff about changing better, or asked the how to handle the During an anonymmember (SM)-A, swith concerns about SM-A stated the stand administration work the past few surveyors] are here home after their she were unable to conthe residents, "The SM-A stated sever recent shift, but on becasue there was the cares, and SM nursing (DON) to severe the state of the state of the cares, and SM nursing (DON) to severe the state of the cares, and SM nursing (DON) to severe the cares.	ne facility was, "Absolutely lent care was suffering. NA-K equently not even a nurse unit (an end-of-life care unit), to wait for long periods of time ts answered because "Weme," to answer them. The done nothing to help with pect the floor staff to get the y come onto the floor when you	F 49			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		31	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAKE BOULEVARD UFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	SM-A stated that m stated administration floor was not typical this week, "Becausare here." During an anonymous "People are quitting raised concerns about three staff on the residents. SM-B stadministration regal having enough staff baths, and groomin however, nothing histaffing, and SM-B how administration During interview on DON stated, "Right staffing [lack of]. It evils." She stated, [human resources] good staff." The Doe everything else that quality deficiencies concerns] There are not be an issue if w floor." The DON cowas well aware of t and the quality concinsufficient staffing, of staff is ongoing, management had of implemented signifit to be flexible with staffing the facility's staffing the facility's staffing the staffing of staff is staffing to be flexible with staffing the facility's staffing the facility's staffing the staffing the facility's staffing the staffing the facility's staffing the facility is staffing the facility	gh staff to provide the bathing. ade her, "Really upset," and on helping with cares on the I, and was only being done e you guys [state surveyors] bus interview, SM-B stated, because of the staffing," and out some shifts with only two e floor to work and care for the ated they spoke to rding the concern of not f to complete timely toileting, g because of the lack of staff, ad been done to fix the lack of had heard nothing further on	F 4	90			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	COMPLETED	
		245513	B. WING _		10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 520 SS=F	maternity leave. The was still accepting is she was aware of some of the things supposed to have a one since Septemb [residents] is getting. When interviewed administrator stated him regarding the last [staff] need more peresident cares. The determined based of they currently had extensive staff assist did cut hours if they and use a formula of the bed equals x amount administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was to hire at had been the focus the administrator stated there is a problem focus was "no stone unture was "no sto	eight facility staff who left on the DON confirmed the facility new admissions, and stated taff concerns of residents who baths or oral cares, and, "This that is tied to staffing. We are a bath aide [but] have not had ter, I think everybody greally good wash ups." on 10/26/15, at 4:24 p.m. the distaff had voiced concerns to tack of staffing and, "They exple", to help complete to facility staffing was on the size of the building, and I many residents who required stance for cares. The facility of are down in resident census, total number of hours divided exidents) to determine the extresident, so being down one ont of dollars." The dishe had "certainly identified with lack of staffing, and the not recruit new staff stating it, "For a long time." Further, ated the facility had "used it more staff, and he felt there are the residents. IBERS/MEET	F 49			12/29/15
	A facility must main	tain a quality assessment and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE
F 520	nursing services; a facility; and at leas facility; and at leas facility's staff. The quality assess committee meets a issues with respect and assurance act develops and impleaction to correct id. A State or the Sec disclosure of the reexcept insofar as a compliance of such requirements of th. Good faith attempt and correct quality a basis for sanction. This REQUIREME by: Based on observative review, the facility's assurance (QA&A) and implement act systematic concern patterns to ensure care and services assessed needs, fr. R73, R27, R19, R4 R85, R118 and R1 with quality of care	tee consisting of the director of a physician designated by the tast other members of the ment and assurance at least quarterly to identify to which quality assessment ivities are necessary; and ements appropriate plans of entified quality deficiencies. The terms of the members of the town of the terms	F 520	F520-F Facility timely submits this responsible plan of correction pursuant to fedestate law requirements. This respond plan of correction are not admor an agreement that a deficiency exist or that a statement of a deficiency exist or that a statement of a deficiency exist or the facility cited or factually basit's not to be construed as an admagainst interest of the facility, the administrator, of any employees, a or other individuals who participated drafting or who may be discussed otherwise identified the same.	eral and conse nissions does ciency sed and ission agents ed in the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245513	B. WING			10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		BE	(X5) COMPLETION DATE
F 520	timely assistance w failed to ensure approducts were prov (R126) who express care and services. > Refer to F242; The bathing preferences reviewed for bathing. > Refer to F244; The prompt responses the staffing concerns. 5 of the 48 resident R21) who regularly meetings from 7/28. > Refer to F282; The appropriate inconting necessary and failed a pressure relieving directed by the writter residents (R126) residents (R126) residents (R126) residents (R126) residents (R126) residents (R127) as failed in the care reviewed for dental to the care reviewed for the care reviewed for dental to the care reviewed for dental to the care reviewed for the care reviewed for dental to the care reviewed for dental to the care reviewed for dental to the care reviewed for the care reviewed for the care r	the facility failed to ensure ith toileting aftercares and propriate incontinence ided, for 1 of 2 residents sed concerns of undignified are facility failed to honor is for 1 of 3 residents (R73) incomplete growth of the facility failed to ensure of grievances related to incomplete grievances related to provide grievance grievances when incomplete grievances gr	F 5	520	It is the policy of Lake Ridge Care to have a Quality Assessment and Assurance Committee that develop implements appropriate plans of accorrect identified quality deficiencies. To assure continued compliance, the following plan has been put into plant 1. Regarding cited residents: Facility Administration met with corner HR to develop a staffing action plant Nov 15. Facility has developed an implemented action plans for cited deficiencies related to the care and services of residents. Quality Assess and Assurance Committee will mee January to review and revise action Cited residents will be invited to the Resident Council meeting on Dece 8th to review Staffing action plan. 2. Actions taken to identify other poresidents having similar occurrence All residents had the potential to be affected. 3. Measures put in place to ensure deficient practice does not recur: Action plans will be developed as infor indicated quality needs as ident Quality Assessment and Assurance Committee. Quality Assessment a Assurance Committee will determine compliance regarding action plantal IDT was educated on QIS QA&A by Dec 2015. Staff was educated on of Quality Assessment and Assurance Committee will determine compliance regarding action plantal IDT was educated on QIS QA&A by Dec 2015. Staff was educated on of Quality Assessment and Assurance Committee will determine compliance regarding action plantal IDT was educated on QIS QA&A by Dec 2015. Staff was educated on of Quality Assessment and Assurance Committee will determine compliance regarding action plantal IDT was educated on QIS QA&A by Dec 2015. Staff was educated on of Quality Assessment and Assurance Committee will determine compliance regarding action plantal IDT was educated on QIS QA&A by Dec 2015.	pos and ction to es. ne ace; porate n on 6 ad I ssment et in n plans. et mber tential es: et end ne areas. y 13 the role	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING			10/:	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	the required assista (R126) reviewed for for 1 of 3 residents choices, for 5 of the R35 and R21) reviewed for 4 residents (R1 ulcers, for 1 of 3 residental hygiene, and R64, R45, R19, and of daily living (ADLs residents (R126, R8 R123, and R27), 2 FM-H), and 13 of 13 NA-I, NA-C, NA-T, OT-K, COTA-J, SM expressed concern insufficient staffing, had potential to affevisitors in the facility. On 10/26/15, at 5:0 (DON) was intervied QA&A committee, committee gathered in effort to identify pwithin the facility. Sincluded care conferonts, verbal and/of family/ residents, reand the on-going repast survey results the committee had that all residents are were asked at each facility was meeting felt they had been to concerns were presidents.	ensure residents received ance for 1 of 2 residents of dignified care and services, (R73) reviewed for bathing at 48 residents (R27, R19, R45, awed for group grievances, for 126) reviewed for pressure sidents (R5) reviewed for dignified for 5 of 6 residents (R5, dignified for 5 of 6 residents (R5, dignified for 5 of 6 residents (R5, dignified for 8 of 9 for 3 of 9 for 4 family members (FM-G, 3 staff members (NA-G, HK-A, NA-K, LPN-F, LPN-B, RN-A, -A and SM-B) interviewed who is and complaints related to and complaints related to this lack of sufficient staff for and the dignified for the pool of those sources for those for th	F 5	20	Committee by 13 Dec 2015. 4.Effective implementation of action be monitored by: Action plans will be monitored for progress towards goals and revise needed. Quality Assurance and Assessment Committee will meet quarterly to determine compliance regarding action plan areas. Administrator will monitor Quality Assurance and Assessment Commaction plan. 5.Those responsible to maintain compliance will be: Administrator is responsible for compliance.	d as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10.	/26/2015
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520	of a quality deficie identified, providin action plans, the Dare just stuck on the other evils." Smake that a QA the HR [human resouretain good staff." almost everything tied into it [staffing many things that we enough people on the QA&A commit facility's staffing stated, the facility's actually developed to address the stath ave done." The Imanagement had implemented signit to be flexible with the facility's staffinend of Summer, we college. She added who had left on me DON confirmed the admissions, but stadmissions until laresident discharge facility's QA&A con addressed concerreceiving baths or "This is one of the we were doing gree of September Waide [but] have not	age 139 Incy the committee had g a description of any resulting DON reported, "Right now we he staffing. It is the driver of all he stated, "I don't know how to ing We work with corporate rees] all the time to get and The DON added, "I think that else that we've identified are concerns] There are so would not be an issue if we had the floor." The DON confirmed tee was well aware of the nortage and the quality from insufficient staffing. She is QA&A committee had not fing concerns within the facility. The defendant of the concerns within the facility. The concerns within the facility offered hiring bonuses, ficant differential pay and tried shift preferences. She stated g shortage began around the then students returned to ed, there were eight facility staff atternity leave as well. The refacility was still accepting new ated they had delayed some ated they had delayed some ater in the week when another and. When asked whether the mittee had identified or the oral cares, she responded, things that is tied to staffing at until the first or second week are supposed to have a bath thad one since September I detting really good wash ups."	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED		
		245513	B. WING		10/26/2015		
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 520		arding the responsibilities of the was requested, but was not	F 5	20			

PRINTED: 12/10/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		A. BUILDIN	IG	COMPLETED
	245513	B. WING		C 10/26/2015
NAME OF PROVIDER OR SUPPL	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313	10/20/2013
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
The facility mus provide nursing maintain the hig and psychosoci determined by rindividual plans The facility mus numbers of eac personnel on a care to all reside care plans: Except when was section, license personnel. Except when was section, the facinurse to serve a duty. This REQUIREI by: Based on obserview, the facil staffing to ensure assistance with reviewed for digresidents (R73) 5 of the 48 residents (R5) reviewed fresidents (R5)	t have sufficient nursing staff to and related services to attain or hest practicable physical, mental, al well-being of each resident, as esident assessments and	F 35	,	and e ons s s cy and
(ADLs). In addi	for activities of daily living tion, for 9 of 9 residents (R126, DVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	administrator, of any employees, agen or other individuals who participated in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

11/27/2015

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.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	СОМ	X3) DATE SURVEY COMPLETED	
		245513	B. WING _			26/ 2015	
NAME OF F	PROVIDER OR SUPPLIER	I.		STREET ADDRESS, CITY, STATE, ZIP C		20/2010	
LAKE DI	DOE OADE OENTED	OF BUFFALO		310 LAKE BOULEVARD			
LAKE RI	DGE CARE CENTER	OF BUFFALO		BUFFALO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 353	2 of 4 family memb 13 staff members (NA-T, NA-K, LPN-F COTA-J, SM-A and concerns and comp staffing. This lack of to affect all 48 residente facility. Findings include: ASSESSED RESID MET: > Refer to F241: Total timely assistance we failed to ensure approducts were provented for each of the facility. > Refer to F242: Total timely assistance were and services. > Refer to F242: Total timely preferences are and services. > Refer to F244: Total timely preferences reviewed for bathin to the facility who regularly meetings from 7/28 > Refer to F282: Total timely assistance were and services. 5 of the 48 residented for the facility who regularly meetings from 7/28 > Refer to F282: Total timely residents (R5) reviewed for the facility meetings from 7/28	5, R73, R35, R123, and R27), ers (FM-G, FM-H), and 13 of NA-G, HK-A, NA-I, NA-C, F, LPN-B, RN-A, OT-K, SM-B) interviewed expressed plaints related to insufficient of sufficient staff had potential dents who currently resided in DENT NEEDS NOT BEING DENT NEEDS NOT BEING The facility failed to ensure vith toileting aftercare's and propriate incontinence rided, for 1 of 2 residents sed concerns of undignified The facility failed to honor is for 1 of 3 residents (R73) in greater to grievances related to the facility failed to ensure to grievances related to This had the potential to affect its (R27, R19, R45, R35 and attended resident council attended resident council sy the care plan for 1 of 3 rewed for dental hygiene.	F 35	drafting or who may be disc otherwise identified the same lt is the policy of Lake Ridge to have sufficient nursing stanursing and related services maintain the highest practice mental and psychosocial we each resident, as determine assessments and individual. To assure continued compliate following plan has been put: 1. Regarding cited residents We have provided written place correction for F-tags F-241 F-242 for R73, F-244 for R2 R35, R21, F-282 for R5 and R64, R44 and R19 relating these cited residents found of our most recent CMS-256 we have and/or will address respective issues. We will dinterview, select and train proposed the care needed residents. 2. Actions taken to identify or residents having similar occursion affected by these deficient practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Administration met with the potential practice does not reacility Ad	e Care Center aff to provide s to attain or able physical, ell-being of ed by resident plans of care. ance, the into place; lans of for R126, e7, R19, R45, e1, F-312 for to the care of in the findings entire to the care of in the findings entire available to these cited entire potential currences: all to be practices.		
		ne facility failed to ensure nail d for 2 of 5 residents (R5,		HR to develop a staffing act Nov 15; corporate HR will po			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING				26/ 2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313		10/1	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 353	(R45, R19), and as provided for 1 of 5 activities of daily liv dependant on staff RESIDENT CONC R126's admission I dated 9/29/15, iden cognition, and required complete ADLs. During interview on stated he had to was his call light answer cares. R126 stated use the restroom as he never knew how answer his call light "Anxious," and "He interview on 10/26/his preference was toileting and not as the response times, he stated, he need held commode, but is unalone, and has to we reported he would be cause he doesn'd does not respond to timely to help onto use the bedpan and prefers to use.	oleted for 2 of 5 residents sistance with toileting was residents (R126) reviewed for ing (ADLs) and who were	F3	353	interviews and assist in hiring until positions are filled, and selection of employees will be done within the requirements of employment law. I schedules have been re-created, a posted for two-week time periods of and any vacant positions are posted the schedule. These vacant hours available to current employees, and also called in to a pool agency if the cannot be filled before the pay periodegins. Variably, weekly orientation also been implemented to assist in getting onto the floor. Bonuses have and will continue to be offered to fill vacant shifts, as well as increased differentials. Advertisements for nuand nursing assistants have been a continue to be placed in local paper online sources, such as Indeed, un positions are filled. Locations that nursing assistant programs have be contacted to let them know of any contacted to let them know of any contacted to let them know of any contacted to attract more applicants. Suggestion box was put into use to input from employees, as well as us annual reviews and the EQIC meet address potential job duty issues. I employees were educated on what doing to attract new employees. Whoping to hire a staffing coordinator assist in scheduling and shift replacement. To allow for the proportion of our residents, we have also addense position, Resident Concierge Representative, to help assist in the needs of our residents.	Nursing nd are r more, d on are d are ey od ns have staff ve been night urses and will rs and till open oppen A solicit sing ing to All we are re to er care ed on a	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245513	B. WING				26/ 2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	10/1	20,2010
					10 LAKE BOULEVARD		
LAKE RI	DGE CARE CENTER	OF BUFFALO			BUFFALO, MN 55313		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353		age 3 cognitive impairment, and sistance from staff for ADLs.	F 3	353	4.Effective implementation of action be monitored by: Open positions and vacant shifts w		
	stated she often hat time to get help to frequently incontin- long. R55 stated	n 10/20/15, at 9:13 a.m. R55 ad to wait for extend periods of the bathroom, and was ent because of waiting for so the facility needed more staff to their cares, "They just don't work."			recorded on the schedule and an explanation of how those open pos or vacant shifts were covered will be written in the nursing schedule. If a cannot be filled for some reason, the Director of Nursing will be contacted that contact, time and vacancy will written in the nursing schedule boo	itions e a shift ne d, and be	
	had intact cognition assistance from st During interview or stated the facility had the past two or threatakes, "Quite awhile	OS dated 9/1/15, identified R85 n, and required extensive aff to complete ADLs. n 10/20/15, at 10:03 a.m. R85 ad been, "Short of staff," for ee months. R85 stated staff e" to answer his call light to e with cares, and it had, "Been a			Director of Nursing will inform the Administrator weekly for two month open nursing department positions shifts unable to be filled and the co action to fill those positions and shi as needed thereafter. All-staff mee will be held monthly for three month Each Employee Quality Improveme Committee meeting will have adeq staffing levels added to the agenda	and urse of fts, and etings as. ent uate	
	R118's admission R118 had intact co assistance from st During interview or stated staffing see in the evenings. R that needed to be resident had to wa complete this whic become saturated	MDS dated 8/24/15, identified gnition, and required limited aff to complete ADLs. n 10/21/15, at 11:34 a.m. R118 ms worst on the weekend and 118 had a dressing change completed, however, the it over 6 hours for staff to h caused the dressing to			reports continuing to be provided to quarterly Quality Assurance and Assessment Committee, to provide system of allowing employees to di staffing levels to see if they are such or not; the minutes of those meeting be posted in the employee lounge. Adequate staffing levels will be on agenda for each care conference, attending residents and families be able to comment on whether changes staffing levels are successful or not Reports of adequate staffing will be evaluated and PDSA models will be implemented to continuously improven thance staffing. This data collect be presented to the Quality Assess	the a a scuss cessful gs will the with ing jes with t. e ve and ed will	
		n, and required extensive			Assurance Committee quarterly me		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245513	B. WING				C 26/2015
_	PROVIDER OR SUPPLIER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD BUFFALO, MN 55313	10/2	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	assistance from star During interview on stated the facility distaff would often costaffed to him, and was only one nurse R5 stated his call ligminutes," to get and the commode for, "staff came to provide R73's admission MR73 had intact cognassistance from star During interview on stated he had waite past for staff assistance all light to be answover worked and unto be provided the required extensive accomplete ADLs. During interview on stated the facility stated the facility stated the facility stated the facility stated the staff to get to the form staff to get to the form staff to get to the staff to get to get to get the staff to get to	off to complete ADLs. 10/20/15, at 9:11 a.m. R5 d not have enough staff, and implain about being short at times R5 had stated there working for an entire shift. If the working for an entire shift on An hour and a half," before the assistance. DS dated 10/1/15, identified and for nearly two hours in the ence to go to bed and for his worked. R73 stated the staff are inder staffed for the residents in ecessary cares in the facility. S dated 10/6/15, identified cognitive impairment, and assistance from staff to 10/20/15, at 10:29 a.m. R35 aff worked short nearly all of had been times R35 would the bathroom but was not receiving timely assistance.	F3	353	and the QA&A committee will make decision/recommendation regarding necessary follow-up audits needing continued. 5. Those responsible to maintain compliance will be: The Director of Nursing will be responsible for compliance.	ig any	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COM	E SURVEY PLETED
		245513	B. WING				C 26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		310	REET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD IFFALO, MN 55313	10/	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	R123 had intact cog assistance from stated she had wait to the restroom, cal diaper," which she is degraded." R27's quarterly MD R27 had intact cograssistance from stated she had wait her call light answe the facility needed to the cares the resident family member in the requesting staff assistance, and waited, staff to respond. The occurrences of wait answered, and FM-response times] conthey had been told they were "Adequated disagreed and the firstaff to help resident."	gnition, and required extensive off to complete ADLs. 10/20/15, at 12:20 p.m. R123 and for over an hour to get help using her to, "Just use my stated made her, "Feel S dated 9/22/15, identified nition, and required extensive off to complete ADLs. 10/20/15, at 10:24 a.m. R27 and to receive assistance, and to have more staff to provide ents needed. NT'S ABOUT STAFFING: 10/21/15, at 11:31 a.m. family ated they had visited their nee past and used the call light sistance and "Waited, and" over twenty five minutes for here had been multiple ting for the call light to be G stated, "It [long call light needed," but stated she acility needed to add more ats with cares.	F3	953			
		10/26/15, at 10:01 a.m. FM-H ed oral cares were frequently					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245513	B. WING		10	C / 26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313		, = 0, = 0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	at the facility. The hour to be answere especially worse of STAFF CONCERN	ed because of the lack of staff call light had taken over one ed in the past, and was	F 35	3		
	nursing assistant (I facility needed more with cares. NA-G secomplain about the and lack of assistant NA-G stated the second care, shaving because of the lack don't have enough residents." NA-G sinjured attempting by themselves becataff on to help us administration tells	NA)-G stated she felt the re staff to assist the residents stated the residents often a long call light response time nee they receive with cares. The cheduled baths and grooming is not always completed a of staffing adding, "[staff] time to take care of the stated several staff had been to care for two assist residents ause, "There's not enough out." NA-G stated the facility staff they, "Are looking into it," if provide the resident cares to				
	housekeeping aide had been short sta had made resident extended periods, rooms and hear re me." HA-A stated concerns staff is un cares, but they tell add more staff, "Bu					
		n 10/22/15, at 1:23 p.m. NA-I at the facility was. "Not good."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245513	B. WING				C 26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER			310 L	EET ADDRESS, CITY, STATE, ZIP CODE LAKE BOULEVARD FALO, MN 55313	10//	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	and there was frequeach hallway to pro The residents frequency in the process of the administration having enough staffing of the residents in the the residents in the the residents have and attention. Nagrooming of resident having enough staffing of the administration having enough staffing of the administration having enough staffing at the staffing of the residents in the the residents in the the residents in the the residents have and attention. Nagrooming of residents have and attention having enough staffing enough staffing interview on stated staffing at the st	uently only one or two NA's on ovide cares to the residents. Juently had to wait, and call wered timely because of the rey [residents] don't get the let." NA-I stated several staff red because they waited for d nobody came, so they sidents in bed by themselves. 10/22/15, at 1:36 p.m. NA-C was "awful," adding the facility ave six or seven NA's to care uring the morning shift, but the only four NA's. NA-C stated exend there would be just two 's to care for all of the nat weekend, no residents duled bathing, and beds were	F3	953			

	D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		COMPLETED		
		245513	B. WING _		10	C / 26/2015		
	PROVIDER OR SUPPLIER	OF BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CO 310 LAKE BOULEVARD BUFFALO, MN 55313		723/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 353	covering the Oasis and residents had to get their call light [staff] don't have tin administration had cares, but "they ex work done and only you guys [state sur During interview or licensed practical r "Not adequate," to needs, and she was facility because she and felt it was bein the lack of staffing as a result. During interview or stated she felt the staff to provide the and residents had and families voice regarding the suffe poor staffing. LPN dressing changes nurse did not have trying to help provide the residents. During interview or registered nurse (Fa "big issue" at the short of help and the overall. RN-A state because of the pool had never asked the staff to provide the short of help and the overall. RN-A state because of the pool had never asked the staff to provide the short of help and the overall. RN-A state because of the pool had never asked the staff to provide the short of help and the short of help and the overall. RN-A state because of the pool had never asked the staff to provide the provide the short of help and the short of the short of help and the short of th	equently not even a nurse unit (an end-of-life care unit), to wait for long periods of time ts answered because "Weme," to answer them. The done nothing to help with pect" the floor staff to get the y come onto the floor, "When						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245513	B. WING _		10	C / 26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313		720/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	During interview or occupational therapist assistance could use more helethey hear from resigned waiting, "Way answered. OT-K as aware of any action address the short of a short of	of to handle the short staffing of to handle the short staffing in 10/26/15, at 2:32 p.m. Dist (OT)-K and occupational in the complex of the complex of the lack of staffing too long for [call] lights," to be and OTA-J stated they were not ins being taken by the facility to staffing concerns. The concerns of the lack of staffing the lack of staff in the facility, was pulling in people to work "Because you guys [state in the lack of staff in the facility, was pulling in people to work "Because you guys [state in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility, was pulling in people to work in the lack of staff in the facility was pulling in people to work in the lack of staff in the facility. The lack of staff in the facility was pulling in people to work in the lack of staff in the facility was people to work in the lack of staff in the facility to staff in the facility was pulling in people to work in the lack of staff in the facility to staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facility to be and of the lack of staff in the facilit	F 38			
	"People are quitting raised concerns ab or three staff on the residents. SM-B st	bus interview, SM-B stated, g because of the staffing," and bout some shifts with only two e floor to work and care for the stated they spoke to arding the concern of not				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245513	B. WING _		10	C / 26/2015
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP COE 310 LAKE BOULEVARD BUFFALO, MN 55313		,=,,=,,=
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353	having enough starbaths, and groomir however, nothing on the 10/19/15, to 10/23/document identified (Oasis, Lake View Northwoods), and a staff members nowere they were school work on the unit. Northwoods each however how	iff to complete timely toileting, and because of the lack of staff, and been done to fix this. Lake Ridge Care Center) displayed the names of the elfoor for each shift, dated 15, were reviewed. The deach unit of the facility Lane, Mill Creek Bridge, and provided blank spaces in which ame was written to identify neduled to work. 10/19/15, the Oasis unit had antified as being assigned to work; and were left with one NA for each unit. The disk of the thirteen spaces if, to be blank. 10/20/15, the Oasis unit again is identified as being assigned. Mill Creek Bridge and the six of the thirteen spaces if, to be blank. 10/20/15, the Oasis unit again is identified as being assigned. Mill Creek Bridge and the process of the spaces with no staff. Both units continued with just the NA working on the floor the residents. The document thirteen spaces used to	F 35	33		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION G	` ´CON	TE SURVEY MPLETED
		245513	B. WING _			C / 26/2015
	PROVIDER OR SUPPLIER	<u>।</u> २		STREET ADDRESS, CITY, STATE, ZIP C 310 LAKE BOULEVARD BUFFALO, MN 55313		20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	identify staff, to be a consumer when stuffing shortage is a stated they had delater in the week will a consumer was staffing sta	_	F 35	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		245513	B. WING			C / 26/2015		
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (ACCUMPANISM OF THE PROCEDED BY FILLIAM OF THE P				STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 353	stated, "This is one staffing we were a second week of Se to have a bath aide September I think good wash ups." During interview on administrator stated determined based of they, "Have a lot of needs." The facility down in census, an number of hours diresidents) to determine the staffing, and the foostaff adding it had be time."	baths or oral cares, DON of the things that is tied to doing great until the first or ptember We are supposed [but] have not had one since a everybody is getting really 10/26/15, at 4:24 p.m. It the facility staffing was on the size of the building, and of residents that have more of duses a formula (total vided by the number of nine the number of hours per down one bed equals, "X. The administrator stated he attified there is a problem" with the cus was to hire and recruit new been the focus, "For a long staffing was requested, but	F3	53				

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245513

B. WING

10/22/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAKE RI	DGE CARE CENTER OF BUFFALO		310 LAKE BOULEVARD BUFFALO, MN 55313	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 00	0	
	FIRE SAFETY			
	THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.			x I
	UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.			A
8	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 22, 2015. At the time of this survey, Building 01 of Lake Ridge Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.			
	PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:		EPOC	×
	Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/27/2015

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.

Facility ID: 00714

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245513 B. WING 10/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 | Continued From page 1 K 000 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE **FOLLOWING INFORMATION:** 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility will be surveyed as two separate buildings. Lake Ridge Care Center is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1976, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is now partially sprinklered based on the K56 tag. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 47 at time of the survey.

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Olvi	B NO.	1930-0391
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01	X3) DATE COMP	SURVEY LETED
I			245513	B. WING			10/2	2/2015
١	NAME OF P	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE		
	1 AVE DU	OCE OADE OENTED	OF BUFFALO		31	I0 LAKE BOULEVARD		
	LAKE KII	OGE CARE CENTER	OF BUFFALO		В	UFFALO, MN 55313		
Date:	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
	K 000	Continued From pa	age 2	K	000			
		NOT MET as evide				÷		40445
	K 056 SS=F		FETY CODE STANDARD	K	056			12/1/15
		installed in accordation the Installation of provide complete of building. The system	natic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the em is properly maintained in FPA 25, Standard for the					
		Inspection, Testing Water-Based Fire I supervised. There supply for the syste	, and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler					1 .
2006			ped with water flow and tamper e electrically connected to the system. 19.3.5					 X
	2	Based on observa staff it was determi sprinkler system ha accordance with N Installation of Sprir "The Life Safety Co section 19.3.5. Thi a fire to progress to negatively effect al	is not met as evidenced by: tions and an interview with ined that the automatic fire as not been installed in FPA 13, Standard for the akler Systems and NFPA 101 bode" 2000 edition (LSC) s deficient practice could allow allowed by the staff and any			K-056 (F) Facility timely submits this response plan of correction pursuant to federa state law requirements. This response or an agreement that a deficiency dexist or that a statement of a deficiency was correctly cited or factually base it's not to be construed as an admis against interest of the facility, the	al and nse ssions oes ency ed and	
		12:00 PM on 10/22	ween between 8:30 AM and 2/2015, observations and an Director of Maintenance			against interest of the facility, the administrator, of any employees, ag or other individuals who participated drafting or who may be discussed o otherwise identified the same.	d in the	

Facility ID: 00714

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	42 LOK MEDICAKE	& MEDICAID SERVICES				VILL INC.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245513	B. WING	2/		10/2	22/2015
	PROVIDER OR SUPPLIER	OF BUFFALO		3	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAKE BOULEVARD SUFFALO, MN 55313	Ti	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 056	revealed that: 1. In the 1960 Add through # 116 clos sprinklered 2. In the 1976 Add through # 135 dou sprinklered only or separated by a sol ceiling creating an	dition, the resident rooms # 103 ets were found not to be dition, the resident rooms # 117 ble closets were found to be none side. These closets are id set of drawers from floor to	K	056	It is the policy of Lake Ridge Care to insure the entire building is fully sprinkled. To assure continued compliance, the following plan has been put into plants. 1. Description of what has been downly be, done to correct the deficier Sprinklers have been installed in a areas, noted in the deficiency that have sprinklers. 2. The actual, or proposed, completed ate: The sprinklers will be completed of 2015. 3. The name and/or title of the personsible for correction and more to prevent a reoccurrence of the deficiency: The Environmental Services Direct be responsible to prevent a reoccurrence of the deficiency.	he ace; one, or ncy: Il the did not tion n 1 Dec	

Facility ID: 00714

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 02 - OASIS B. WING 245513 10/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lake Ridge Care Center, Oasis wing (2014 addition) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility will be surveyed as two separate buildings. Lake Ridge Care Center Oasis Wing is a 1-story building built in 2014 and was determined to be of Type 11 (111) construction. The building is fully sprinkled protected. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 47 at the time of the survey. EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/27/2015

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.

Facility ID: 00714



Electronically delivered November 19, 2015

Mr. Jason Nelson, Administrator Lake Ridge Care Center Of Buffalo 310 Lake Boulevard Buffalo, Minnesota 55313

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5513025, H5513019

Dear Mr. Nelson:

The above facility was surveyed on October 19, 2015 through October 26, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5513019. that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Lake Ridge Care Center Of Buffalo November 19, 2015 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer at (320) 223-7338 or email: brenda.fischer@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING	·····	10/26/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
LAKE RI	DGE CARE CENTER	OF RUFFALO	E BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	ETE.
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tagule number indicated below. In the items will be considered be been been been been been been been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/27/15 **Electronically Signed**

TITLE

10/26/2015

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

(X3) DATE SURVEY COMPLETED

00714

B. WING ___

	NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF BUFFALO STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 19th, 20th, 21st, 22nd, 23rd and 26th 2015, surveyors of this Department's staff,	2 000						
	visited the above provider and the following correction orders are issued. In addition, a complaint investigation was completed for H5513019 and substantiated. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.							
	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.							
	PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,							

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING				
		00714			10/2	6/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S BOULEVAF	STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	OF RUFFALO	, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.						
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 130	MN Rule 4658.0056 duties	0 Subp. 1 Licensee;General	2 130			12/29/15	
	nursing home is rescontrol, and operation managed, controlle that enables it to us efficiently to attain of	I duties. The licensee of a sponsible for its management, ion. A nursing home must be d, and operated in a manner se its resources effectively and or maintain the highest I, mental, and psychosocial resident.					
	by: Based on interview facility failed to ens assessed and deve inadequate staffing during the recertific	and document review, the ure administration effectively eloped a plan to address the in the facility as identified ation survey. This had II 48 residents residing in the		Corrected.			
	Findings include:						
	adequate staffing to the required assista (R126) reviewed fo	facility failed to provide o ensure residents received ance for 1 of 2 residents r dignified care and services, (R73) reviewed for bathing					

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAK	DDRESS, CITY, S E BOULEVAR D, MN 55313	TATE, ZIP CODE D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 130	choices, for 5 of the R35 and R21) reviet 1 of 4 residents (R1 ulcers, for 1 of 3 residental hygiene, and R64, R45, R19, and of daily living (ADLs residents (R126, R8 R123, and R27), 2 FM-H), and 13 of 13 NA-I, NA-C, NA-T, OT-K, COTA-J, SM expressed concern insufficient staffing. had potential to affevisitors in the facility. During interview on nursing assistant (N facility needed more with cares. NA-G scomplain about the and lack of assistant NA-G stated the sc (nail care, shaving) because of the lack don't have enough residents." NA-G sinjured attempting the bythemselves because of the lack don't have enough residents." NA-G sinjured attempting the bythemselves because of the lack don't have enough residents. "NA-G sinjured attempting the bythemselves because of the lack don't have enough residents." NA-G sinjured attempting the bythemselves because of the lack don't have enough residents. "NA-G sinjured attempting the bythemselves because of the lack don't have enough residents." NA-G sinjured attempting the bythemselves because of the lack don't have enough residents. "NA-G sinjured attempting the but rarely help staff ensure they are bein administration revisites ponsibility.	e 48 residents (R27, R19, R45) wed for group grievances, for 26) reviewed for pressure sidents (R5) reviewed for d for 5 of 6 residents (R5, d R126) reviewed for activities s). In addition, for 9 of 9 55, R85, R118, R5, R73, R35, of 4 family members (FM-G, 3 staff members (NA-G, HK-ANA-K, LPN-F, LPN-B, RN-A, -A and SM-B) interviewed who is and complaints related to This lack of sufficient staff ect all 48 residents, staff and				
	housekeeping aide	(HA)-A stated the nursing staffed lately. The lack of staff	f			

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 4 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	10/2	.0/2013
	DGE CARE CENTER	310 I AKF	BOULEVAR			
LAKE NI	DGE CARE CENTER	BUFFALO), MN 55313			I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 130	Continued From pa	age 4	2 130			
	extended periods, a rooms and hear resme." HA-A stated concerns staff is urcares, but they tell add more staff, "BuDuring interview on stated the facility was care was suffering instances of only offor residents in the the residents have and attention. NAgrooming of reside times," because of are not able to be administration held with all staff and tall staffing, however, rimprove the lack of can be completed,	n 10/22/15, at 1:53 p.m. NA-T has short staffed and resident as a result. There had been ne NA on each hallway to care past, and when that occurs to, "Just wait," to receive care T stated the bathing and nts had suffered, "Lots of the poor staffing and the cares completed. NA-T stated the a meeting a few months ago liked about solutions to short nothing had been done to staff to ensure resident cares and administration had not any what is being done to meet				
	stated staffing at the horrible," and reside stated there was from covering the Oasis and residents had to get their call light [staff] don't have tire administration had cares, but they exp	in 10/22/15, at 2:20 p.m. NA-K are facility was, "Absolutely ent care was suffering. NA-K equently not even a nurse unit (an end-of-life care unit), to wait for long periods of time its answered because "We me," to answer them. The done nothing to help with lect the floor staff to get the y come onto the floor when you ors] are here."				
	During interview on	n 10/23/15, at 11:52 a.m.				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 5 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00744	B. WING		40/0	0.4004.5
		00714	b. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 130	registered nurse (Ra "big issue" at the short of help and the being completed as several staff had re staffing, and admin staff about changin better, or asked the how to handle the surveyors and administration work the past few concerns about SM-A stated the stand administration work the past few concerns about surveyors are here home after their shift were unable to complete the cares, and SM-nursing (DON) to sit they were complete there was not enout SM-A stated that most administration floor was not typical this week, "Becaus are here."	N)-A stated staffing had been facility. The floor staff are e residents care was not assessed. RN-A stated signed because of the poor istration had never asked the g hours to balance the work resigning floor staff's input on short staffing situation. Sus interview with a staff everal issues were presented at the lack of staff in the facility. Affing was, "bad" at the facility, was pulling in extra staff to lays, "Because you guys [state etc." SM-A stated they often go iff and feel bad because they applete their jobs and care for cares are just not good." All baths were scheduled for a sy two of them were completed not enough staff to provide A was told by the director of ign the care sheets identifying ed, although DON was aware gh staff to provide the bathing. The add her, "Really upset," and on helping with cares on the li, and was only being done e you guys [state surveyors] Sus interview, SM-B stated, the provide is surveyors of the staffing," and out some shifts with only two endoor to work and care for the	2 130			

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 6 of 137

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR	BD.		
0(0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	, MN 55313	DDOVIDED'S DI ANI OF CODDECTIO	DNI .	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 130	Continued From pa	ge 6	2 130			
	baths, and grooming because of the lack of staff, however, nothing had been done to fix the lack of staffing, and SM-B had heard nothing further on how administration will resolve this.					
	now we are just stuis the driver of all the "We work with corpall the time to get DON added, "I think that we've identified deficiencies] are tied. There are so many issue if we had eno DON confirmed fact aware of the facility quality concerns restaffing, however, tongoing. The DON had offered hiring be significant different with shift preference.	6 p.m. DON stated, "Right ck on the staffing [lack of]. It he other evils." She stated, orate HR [human resources] and retain good staff." The ke that almost everything else d [as potential quality d into it [staffing concerns] things that would not be an ugh people on the floor." The sility management was well 's staffing shortage and the sulting from insufficient he concern of lack of staff is stated facility management onuses, implemented al pay, and tried to be flexible es. She stated the facility's egan around the end of				
	summer, when study well as eight facility leave. The DON control accepting new admaware of staff concreceiving baths or of the things that is ties supposed to have a one since Septemb [residents] is getting. When interviewed of administrator stated based on the size of currently had many	dents returned to college, as staff who left on maternity onfirmed the facility was still hissions, and stated she was erns of residents who were not oral cares, and, "This is one of the dot of the think everybody greally good wash ups." on 10/26/15, at 4:24 p.m. the dother than the staffing was determined of the building, and if they residents who required stance for cares. The facility				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 7 of 137

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY PLETED	
7.1.12 1 2.111	o. co		A. BUILDING:			
		00714	B. WING		10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 130	did cut hours if they and use a formula oby the number of renumber of hours per bed equals x amou administrator stated there is a problem focus was to hire an had been the focus the administrator stated everything to recruwas "no stone unture issue of the lack of necessary cares for SUGGESTED MET The facility administration. The facility administration. Respondent to the sum of the	v are down in resident census, (total number of hours divided esidents) to determine the er resident, so being down one nt of dollars." The d he had "certainly identified with lack of staffing, and the nd recruit new staff stating it , "For a long time." Further, eated the facility had "used it more staff, and he felt there rned" in trying to address the staffing to provide the	2 130			
2 255	Assurance Commit A nursing home musesessment and as of the administrator services, the medic designated by the rethree other member representing disciparesident care. The assurance committed respect to which quantum committed the services of the service	O Quality Assessment and tee ust maintain a quality surance committee consisting r, the director of nursing all director or other physician medical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with a lity assurance activities are elop and implement	2 255			12/29/15

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, BOULEVAL BOULEVAL D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 255	appropriate plans of quality deficiencies. address, at a minim reporting, infection pharmacy services. This MN Requirements by: Based on observative review, the facility's assurance (QA&A) and implement active systematic concern patterns to ensure of care and services in assessed needs, for R73, R27, R19, R4 R85, R118 and R12 with quality of care. This had the potent the facility. Findings include: *Refer to F241: The timely assistance we failed to ensure approducts were proved (R126) who expressed and services. *Refer to F242: The bathing preferences are and services. *Refer to F244: The prompt responses to staffing concerns. Sof the 48 resident.	f action to correct identified. The committee must hum, incident and accident control, and medications and ent is not met as evidenced on, interview and document quality assessment and committee failed to develop on plans to address identified, s of inadequate staffing residents were provided with accordance with their or 13 of 42 residents (R126, 5, R35. R21, R5, R64, R55, R23) reviewed for compliance and quality of life regulations. ial to affect all 48 residents in efacility failed to ensure ided, for 1 of 2 residents sed concerns of undignified efacility failed to honor for 1 of 3 residents (R73)	2 255	Corrected.		

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	E BOULEVAF O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 255	Continued From pa	age 9	2 255			
	meetings from 7/28	3/15 to 9/29/15.				
	appropriate incontir necessary and faile a pressure relieving directed by the writt residents (R126) re The facility also fail directed by the care reviewed for dental *Refer to F312: The care was completed R64), bathing comp (R45, R19), and as provided for 1 of 5 in the care was provided for 1 of 5 in the care was completed R64).	e facility failed to ensure nail d for 2 of 5 residents (R5, oleted for 2 of 5 residents sistance with toileting was residents (R126) reviewed for ing (ADLs) and who were				
	adequate staffing to the required assista (R126) reviewed fo for 1 of 3 residents choices, for 5 of the R35 and R21) revie 1 of 4 residents (R1 ulcers, for 1 of 3 red dental hygiene, and R64, R45, R19, and of daily living (ADLs residents (R126, R1 R123, and R27), 2 FM-H), and 13 of 13 NA-I, NA-C, NA-T, OT-K, COTA-J, SM expressed concern insufficient staffing.	te facility failed to provide of ensure residents received ance for 1 of 2 residents or dignified care and services, (R73) reviewed for bathing et 48 residents (R27, R19, R45, etwed for group grievances, for 126) reviewed for pressure sidents (R5) reviewed for d for 5 of 6 residents (R5, d R126) reviewed for activities activities. In addition, for 9 of 9 s55, R85, R118, R5, R73, R35, of 4 family members (FM-G, 3 staff members (NA-G, HK-A, NA-K, LPN-F, LPN-B, RN-A, I-A and SM-B) interviewed who is and complaints related to . This lack of sufficient staff ect all 48 residents, staff and				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 10 of 137

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D WING			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
I AKF RI	DGE CARE CENTER	DE BLIEFALO	BOULEVAF			
		BUFFALC), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	Continued From pa	ge 10	2 255			
	visitors in the facility	/ .				
	On 10/26/15, at 5:0 (DON) was intervied QA&A committee. committee gathered in effort to identify pwithin the facility. Sincluded care conferons, verbal and/ofamily/ residents, reand the on-going repast survey results the committee had that all residents and were asked at each facility was meeting felt they had been to concerns were prescommittee. When a of a quality deficient identified, providing action plans, the DO are just stuck on the other evils." Shomake that a QA thir HR [human resource retain good staff." almost everything estied into it [staffing of many things that we enough people on the QA&A committer facility's staffing shoconcerns resulting is stated, the facility's actually developed to address the staff	6 p.m. the director of nursing wed regarding the facility's The DON reported the QA&A data from numerous sources obtential quality deficiencies from of those sources before reports, facility concern remarked with a stisfaction surveys eview of audit results, from or other quality deficiencies identified. The DON reported door their representatives a care conference whether the atheir needs and whether they reated well. Any identified sented to the QA&A asked to provide an example cy the committee had a description of any resulting DN reported, "Right now we staffing. It is the driver of all e stated, "I don't know how to ag We work with corporate estated, "I don't know how to ag We work with corporate encorerns] There are so build not be an issue if we had the floor." The DON confirmed the was well aware of the concerns and the quality from insufficient staffing. She QA&A committee had not or implemented an action planting concerns within the facility, d, "We report to QA what we				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 11 of 137

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	implemented signifit to be flexible with sithe facility's staffing end of Summer, who college. She added who had left on man DON confirmed the admissions, but state admissions until lateresident discharged facility's QA&A come addressed concerning baths or confirmed the two were doing great of September We aide [but] have not think everybody is gother QA&A committed provided. SUGGESTED MET The medical director of nursing of facility policies and responsibilities of the Assurance committed procedures. Identification be prioritized and entered the summer of the significant could be re-educated procedures. Identification of the summer of the prioritized and entered the summer of	ge 11 ffered hiring bonuses, cant differential pay and tried hift preferences. She stated shortage began around the len students returned to differentially staff ternity leave as well. The facility was still accepting new ted they had delayed some er in the week when another differentially leave with the mittee had identified or so of residents who were not wall cares, she responded, hings that is tied to staffing It until the first or second week are supposed to have a bath had one since September I yetting really good wash ups." Interpretation of the could review and/or revise procedures related to the leave Quality Assessment & lea Quality Assessment & lea Quality Assessment & lead on these policies and lied quality deficiencies could valuated for action plans. R CORRECTION: Thirty (30)	2 255			
2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus	2 265			12/29/15

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 12 of 137

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING	·		
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF RUFFALO	E BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 12	2 265			
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the have criteria which appropriate notifica					
		involving the resident which I has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ration in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision tresident from the n	o transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths.				
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview and document ailed to update the medical ashion for 1 of 1 residents		Corrected.		

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 13 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	(R118) who express pain and 1 of 1 resists blood sugars required Findings include: R118's admission of the dated 8/24/15, identification of the day activities of date of the day activity, was free venous ulcer. R118's pain Care A 8/24/15, identified of the day activity, was free venous ulcer. R118's pain Care A 8/24/15, identified of the day activity, was free venous ulcer. R118's pain Care A 8/24/15, identified of the day activity, was free venous ulcer. R118's pain Care A 8/24/15, identified of the day activity, was free venous ulcer. During observation 11:30 a.m. R118 was and applying an ice complained of unmoren sore to her rigiust had a routine of the area, and the probanges, "Hits over numeric pain rating most intense pain in was treated with pathe dressing change think of it."	sed concerns of unmanaged dent (R45) who developed low	2 265			

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 14 of 137

Minnesota Department of Health

winnesc	<u>ita Department of He</u>	aitn					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
		310 Δ	KE BOULEVAR				
LAKE RI	DGE CARE CENTER	BUFFAI	_O, MN 55313	T		ı	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 265	Continued From pa	age 14	2 265				
	her room, receiving from licensed pract LPN-F and R118 coapain medication (medication to treat liked to wait "for he dressing change was LPN-F to return in a dressing change ar 10:01 a.m., R118 sonever quite cuts it there's nothing [that 10:11 a.m., LPN-F dressing change. Wroom, R118 was as medications were hodes," and rated he pain scale. At 10:16 R118's resident roop preparations for the about to begin the town where's my ice parations for the about to begin the town where's my ice parations. R118 said that now." LPN-F so retrieved an ice parations of the Kerlix (gauze be highly absorbent dressing change. At the Kerlix (gauze be highly absorbent dressing change as aline pieces of Silversorb slough, by wiping, recolored debris from LPN-F was removing completing debrid wincing, jerking and	g her morning medications tical nurse (LPN)-F. Both confirmed she had just receive (Gabapentin 300 mg, pain nerve pain) and she typically or pain pill to kick in," before he as completed. R118 asked a half hour to complete her nd to bring an ice pack. At tated, "[Her pain medication]. when they start scraping, at could stop the pain]." At gathered supplies for R118's While LPN-F was outside of the sked whether her pain nelping. She stated, "[It] never pring a seven, out of 0-10 6 a.m. LPN-F returned to	er e e				

Minnesota Department of Health

eyes, which she wiped with tissue paper that she

STATE FORM 6899 28WI11 If continuation sheet 15 of 137

Minnesota Department of Health	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET	
00714 B. WING 10/26/3	2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
held in her hand throughout the dressing change. During the dressing change R118 made LPN-F stop and pause several times, to take a breath and breathe before continuing. When R118 was ready for LPN-F to proceed with the dressing change she would take a deep breath, grimacing her face, and choked with emotional tone to her voice, and said "okay." At 10:29 a.m., R118 stated, "Okay, "it's starting to burn." LPN-F asked R118 if she had not left enough time for her pain medication to begin working. R118 replied, "No, I'm just gonna have to get something stronger for the pain." As soon as LPN-F applied the Kerlix, R118 immediately applied the ice pack to her right lower leg and made LPN-F stop before the stockinet and gripper socks were applied, allowing R118 to breathe, and rest after the dressing change was completed. LPN-F used that time to administer another PRN pain medication (oxycodone 5mg 1 tablet, narcotic pain medication) to R118. LPN-F administered the medication, applied R118's stockinet and gripper stocks, and at 10:37 a.m., left the room. R118 rated her pain as a nine, and during the dressing change, stated. "It's gotta hit 15, because I'm about ready to pass out from the pain." At 10:43 a.m., R118 was still holding the ice pack, firmly to her leg. At 10:45 a.m., R118 rated her pain as an eight (8) and stated her pain level was starting to decline at this time. LPN-F did not ask R118 to rate her pain before, during or after the dressing change even though LPN-F administered PRN pain medication to R118. During interview on 10/22/15, at 10:51 a.m. LPN-F stated R118 had verbal and non-verbal pain indicators during the dressing change, was typical for her. LPN-F stated R118's doctor and purse practitioner were aware of R118's pain, and	

R118's pain management regimen consisted of Minnesota Department of Health

Minnesota Department of Health

AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
I AKE RI	DGE CARE CENTER	OF RUFFALO 310 LA	KE BOULEVAF	RD		
BUFFALC			LO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 16	2 265			
	then oxycodone (a Ultram was not efferesident could also relieve the pain. LF of any changes in F was not sure if any cin medication with F R118's physician pr 10/26/15, included in Examination, comp (MD)-A dated 9/3/19 osteoarthritis affecting, with residual page 10 page 12 page 13 page 14 page 15 pa	rogress notes from 8/17/15, t	re			
	had complaints of p with dressing chang On 9/10/15, NP-A n R118's right lower let treatments. NP-A newill add oxycodone pain." On 9/23/15, a Would History and Physica the anteromedial poleg that measured of (centimeters) and we initially tried to dress however, the patient with this. R118 was her pain got better lon 10/8/15, NP-A a lower leg ulcer. NP-	practitioner (NP)-A noted R11 pain to her right lower extrem ges. Noted the appearance of eg and reviewed the dressing oted, "Discussed pain control for mod [moderate]/severe and Care/ Hyperbaric Medicinal noted, there was a wound portion of (R118's) right lower 11 x (by) 12.5 0.1 cm was very tender to touch. The sthe wound with Medihoney at developed a lot of discomfor given a oxycodone and once her wound was then dressed addressed R118's chronic right owning and awaiting R [right]	e on y; ort			

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 17 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
	00714		B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	LE [lower extremity [Complains of] pain On 10/19/15, NP-A room visit was revie address R118's stal Review of R118's con 10/26/15, directed to and pain managem. Wound treatment for lower extremity-cled dressing daily and Increasing daily and	I dressing [change]. C/o to R LE. noted R118's emergency ewed. The note did not sis ulcer. urrent physician orders dated the following wound treatment ent regimen: to stasis ulceration on right eanse wound, and change PRN. illigrams (mg), twice daily for thy/ polyneuropathy. ry four hours PRN for pain, for ome. every four hours PRN for pain am, for chronic pain syndrome. Electronic Medication ord (EMAR) from 9/1/15, to the following as PRN pain administered for right, lower	2 265			
		oses of pain medication for				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 18 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		A. BUILDING:				
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 265	right, lower extremi doses of Ultram 50 of 49 opportunities; and not effective 6 R118 had 51 doses October 2015 which opportunities; slight effective 5 out of 5 identified, 1 out of 5 identified, 2 out of 5 identified, 3 out of 5 identified, 1 out of 5 identified, 1 out of 5 identified, 2 out of 5 identified, 2 out of 5 identified, 2 out of 5 identified, 3 out of 5 identified, 2 out of 5 identified, 3 out of 5 identified, 2 out of 5 identified, 2 out of 5 identified, 3 out of 5	ty leg pain. She took 49 mg, which was effective 18 out slightly effective 17 out of 49; out of 49 opportunities. of PRN oxycodone 5mg, in h was effective 34 out of 51 tly effective 11 out of 51; not 1 and other, which was not 51 opportunities. R PRN administration times October 2015, did not 's dressing changes, because es were not consistently was administered 203 doses ation, taken in 55 days, doses of PRN pain medication h her scheduled Gabapentin v. R118 continued to ant pain with her dressing ursing progress notes from 7/15, included the following of poor pain control: o.m. registered nurse (RN)-C sed to have dressing put on in art hurting again [R118] is	2 265			
		ower extremity; somewhat				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 19 of 137

Minnesota Department of Health

AND FLAN OF CORRECTION IDENTIFICATION NOWIDER. A. BUILDING:	URVEY ETED
D. WING	
00714 B. WING 10/26/201	/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	(X5) COMPLETE DATE
relieved with prn tramadol, ice, and oxycodone; dressing changed by DON [director of nursing]." On 9/23/15, 10:39 p.m. LPN-I noted, "[R118 was] medicated as directed for leg pain. [R118] states, "It burns so bad when drainage is left on my leg." On 10/8/15, at 2:09 p.m. LPN-F noted, "[R118] continues to c/o pain et request frequent dressing changes et PRN pain meds which were helpful when 2 different PRN pain meds which were helpful when 2 different PRN pain meds which were helpful when 2 different PRN pain meds which were helpful when 2 different PRN pain meds which were helpful when 2 different PRN pain meds which were helpful when 2 different PRN pain meds were given closer together." On 10/17/15, at 11:37 p.m. LPN-D noted, "[R118] rates RLE pain 7/10, somewhat relieved with ice pack and PRN pain medication." During interview on 10/26/15, at 2:32 p.m. registered nurse (RN)-H reported R118's physician was at the facility every Thursday and he was responsible for monitoring to ensure her pain management regimen was sufficiently effective. When asked when the last time was that R118's physician was updated on and/or addressed R118's pain management, RN-H confirmed the most recent notation of the physician/ nurse practitioner having commented on her pain in physician progress notes, was on 10/8/15. RN-H stated that she was aware R118 had significant pain with dressing changes, but believed the current pain management regimen was effective for her. RN-H denied any reports of pain management concerns for R118, from the facility nurses or NAs and would expected her staff would have updated the physician il/when they identified unmanaged pain, to makes changes to her pain regime. R45's annual MDS dated 8/11/15, indicated she was cognitively intact, had diabetes mellitus and received insulin daily. Lake Ridge Care Center signed Physician Order	

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 20 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00714	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER	310 I Ak	ADDRESS, CITY, S			
LAKE RI	DGE CARE CENTER	()F BUFFAL()	.O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 20	2 265			
	Report dated 4/20/subcutaneous once	15, indicated Lantus 37 units in morning.				
		ice visit note dated 4/20/15, our Plan" back on lantus 37				
	4/30/15, indicated L morning with a star HS (at bed time), w Diabetic Administra	ninistration History 4/1/15, to Lantus 37 units once in t date of 4/17/15 and Lantus a rith a start date of 4/20/15. The tion History report indicated us 37 units at HS from 4/20/15	Э			
	4/8/15, indicated at Lake Ridge care ce	Felephone order report dated 8:58 a.m. received call from enter, had blood sugar of 67 orders to call if below 80.				
	dated 4/27/15, Dr. / p.m., "Discussed w 4/20/15 visit, had w units at bedtime wh daily MORNING DO patient has been re daily since the last sugars." Dr. Anders	nic Telephone order report Anderson indicated at 5:34 ith (staff) by phone. As of ritten to return to Lantus 37 iten it should have been once DSE> Clarified with (staff) receiving lantus 37 units twice visit with recent low blood son then ordered Lantus 37 he morning as prior to hospital	al			
	on 4/22/15, at 7:44 only 52 mg/dl (millig	enter Vitals Report identified a.m. R45 blood glucose was grams per deciliter). Review o did not indicate the physician low blood glucose.				
		Note dated 4/25/15, indicated only 51 while R45 was eating				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 21 of 137

Minnesota Department of Health

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 21	2 265			
		Review of the medical record physician was notified of the				
	a.m. blood sugar of	Note dated 4/26/15, at 3:30 f 51. Review of the medical ate the physician was notified cose.				
	a.m. indicated "Res sugar) this morning	Note dated 4/27/15, at 8:33 sident had low BS (blood was sweating and shaky. she physician was called at 8:44				
	p.m. indicated "Res Lantus 37 units BID miscommunication appointment. Spoke	Note dated 4/27/15, at 5:37 sident had been receiving 0 (twice a day) since 4/20, written upon return from e with Dr. Anderson and the d/c'd (discontinued) and will ts in AM."				
	DON who stated sh discrepancy and sta a medication error. nurses should have they noted the orde	/26/15, at 9:30 a.m. with the ne was not aware of the insulin ated she was unable to locate. The DON further stated the exalled the physician when or for Lantus to be given at HS on that before and because of rs.				
	if blood sugars were	an order to notify the physician e below 80, the facility did not of the three low blood sugars.				
	Status policy dated the policy of Elim C	ge in Resident's Condition Or 7/14, directed "POLICY: It is are, Inc. to promptly notify the Attending Physician, and				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 22 of 137

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BOILBING.			
		00714	B. WING		10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF , MN 55313	ID		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	representatives of o	ge 22 changes in the resident's dition and/or status."	2 265			
	The director of nurs and/or revise facility related to physician personnel could be and procedures. A made to the physic identified in the def documentation mai could be evaluated notifications. An au developed and imp with the facility's Qu	HOD OF CORRECTION: sing or designee, could review y policies and procedures notification. Responsible re-educated on these policies ppropriate notices could be ian's of the individual(s) iciency, with supporting ntained. Other residents for appropriate physician uditing system could be lemented, with results shared uality Assessment & ee, to ensure on-going				
2 565	(14) days.	R CORRECTION: Fourteen 5 Subp. 3 Comprehensive	2 565			12/29/15
2 300	Plan of Care; Use Subp. 3. Use. A co	omprehensive plan of care I personnel involved in the	2 000			12/23/13
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview and document ailed to provide oral cares as e plan for 1 of 3 residents (R5) hygiene.		Corrected.		

Minnesota Department of Health

Minnesota Department of Health

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 23	2 565			
	Findings include:					
	9/15/15, identified F	num Data Set (MDS) dated R5 had intact cognition, and assistance with personal orushing his teeth.				
	was seated in a rec showed he had sev	on 10/20/15, at 9:16 a.m. R5 diner chair in his room, and reral missing teeth on his asked about his oral health.				
	an, "Alteration in AI dressing, grooming care plan directed s	d 7/14/15, identified R5 had DLs [activities of daily living] of and bathing". Further, the staff to assist R5 with, "Oral and pm [evening]"				
	stated the care plar [staff] supposed to NA-F helped R5 ge offer or assist him t Further, NA-F state having his teeth bru	10/23/15, at 12:55 p.m. NA-F is used to know "what we're do" for the residents care. It ready for the day, but did not o complete oral cares. It is shed and cleaned so R5 all disease, or loose additional				
	stated R5 needs to complete oral cares	on 10/23/15, at 1:04 p.m. RN-A be set up with assistance to s, and NA-F should have es, "That's what should be				
	A facility policy regaimplementation was provided.	arding care plan s requested, but was not				
	SUGGESTED MET	HOD OF CORRECTION:				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 24 of 137

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00714	B. WING		10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	ΩΕ ΒΠΕΕΔΙ Ω	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	and/or revise facility related to implement Responsible personates these policies and particles for the individual deficiency could be their written plan of the evaluated for calculating system continuous modern and the continuous facility of the continuous facili	sing or designee, could review y policies and procedures ntation of resident care plans. In the could be re-educated on procedures. Care and ividual(s) identified in the monitored for compliance with care. Other residents could re plan implementation. An all the developed and results shared with the facility's t & Assurance committee, to	2 565			
2 800	ensure on-going co TIME PERIOD FOR one (21) days.	mpliance. R CORRECTION: Twenty- O Subp. 1 Nursing Personnel;	2 800			12/29/15
	home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and one than one building is udes relief duty, weekends, tements.				
	by: Based on observation review, the facility for staffing to ensure reassistance with car reviewed for dignification.	ent is not met as evidenced ion, interview, and document ailed to provide adequate esidents received the required es for 1 of 2 residents (R126) ed care and services, for 1 of 3 iewed for bathing choices, for		Corrected.		

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 25 of 137

Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00714	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAK	DDRESS, CITY, S E BOULEVAF O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 800	5 of the 48 resident R21) reviewed for gresidents (R5) reviewed for Gresidents R126) reviewed for (ADLs). In addition R55, R85, R118, R82 of 4 family memb 13 staff members (NA-T, NA-K, LPN-F COTA-J, SM-A and concerns and comp staffing. This lack of to affect all 48 residente facility. Findings include: ASSESSED RESID MET: *Refer to F241: The timely assistance we failed to ensure approducts were proven (R126) who expressionare and services. *Refer to F242: The bathing preferences reviewed for bathing the staffing concerns. Sof the 48 resident R21) who regularly meetings from 7/28	s (R27, R19, R45, R35 and group grievances, 1 of 3 ewed for dental hygiene, and (R5, R64, R45, R19, and activities of daily living, for 9 of 9 residents (R126, 5, R73, R35, R123, and R27), ers (FM-G, FM-H), and 13 of NA-G, HK-A, NA-I, NA-C, F, LPN-B, RN-A, OT-K, SM-B) interviewed expressed plaints related to insufficient of sufficient staff had potential lents who currently resided in DENT NEEDS NOT BEING DENT NEE				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 26 of 137

Minnesota Department of Health

AND BLAN OF CORRECTION TO THE TOTAL NUMBER.		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF BUFFALO	(E BOULEVAF LO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 800	cares as directed by residents (R5) review as completed R64), bathing comp (R45, R19), and as provided for 1 of 5 ractivities of daily livid dependant on staff RESIDENT CONCER R126's admission Mated 9/29/15, ident cognition, and required complete ADLs. During interview on stated he had to was his call light answer cares. R126 stated use the restroom and he never knew how answer his call light "Anxious," and "Hell interview on 10/26/1 his preference was toileting and not a bresponse times, he stated, he need hell commode, but is unalone, and has to wreported he would it commode for toiletic because he doesn't does not respond to timely to help onto the care was to help onto the care as a direction of the commode for toiletic because he doesn't does not respond to timely to help onto the care was to help onto the care as a direction of the care was to help onto the care as a direction of the care was to help onto the care as a direction of the care was to help onto t	y the care plan for 1 of 3 ewed for dental hygiene. e facility failed to ensure nail d for 2 of 5 residents (R5, pleted for 2 of 5 residents sistance with toileting was residents (R126) reviewed for ing (ADLs) and who were	e od e			

Minnesota Department of Health

Minnesota Department of Health

AND BLAN OF CORRECTION \ IDENTIFICATION NUMBER:					SURVEY LETED	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	E BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 27	2 800			
	R55 had moderate required limited ass During interview on stated she often had time to get help to the frequently incontine long. R55 stated the requirement of the	S dated 9/15/15, identified cognitive impairment, and istance from staff for ADLs. 10/20/15, at 9:13 a.m. R55 d to wait for extend periods of he bathroom, and was int because of waiting for so ne facility needed more staff to their cares, "They just don't work."				
	had intact cognition	S dated 9/1/15, identified R85, and required extensive ff to complete ADLs.				
	stated the facility ha the past two or thre takes, "Quite awhile	10/20/15, at 10:03 a.m. R85 ad been, "Short of staff," for e months. R85 stated staff "to answer his call light to with cares, and it had, "Been a				
	R118 had intact cog assistance from sta During interview on stated staffing seen in the evenings. R1 that needed to be c resident had to wait	MDS dated 8/24/15, identified gnition, and required limited aff to complete ADLs. 10/21/15, at 11:34 a.m. R118 as worst on the weekend and l18 had a dressing change ompleted, however, the cover 6 hours for staff to a caused the dressing to and drip fluids.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF RUFFALO	E BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	R5's quarterly MDS had intact cognition assistance from stated the facility distaff would often costaffed to him, and was only one nurse R5 stated his call ligminutes," to get and the commode for, "staff came to provide R73's admission MR73 had intact cognassistance from stated he had waite past for staff assistance from stated he had waite past for staff assistance and unto be provided the required extensive acomplete ADLs. During interview on stated the facility stated the facility stated the facility stated the facility stated the wait to use	dated 9/15/15, identified R5, and required extensive off to complete ADLs. 10/20/15, at 9:11 a.m. R5 do not have enough staff, and implain about being short at times R5 had stated there working for an entire shift. If the working for an entire shift of the working for an entire shift of the working for an entire shift. If the working for an entire shift of the working for an entire shift of the working for an entire shift of the working for an entire shift on An hour and a half," before the assistance. DS dated 10/1/15, identified antition, and required extensive of the complete ADLs. 10/21/15, at 10:55 a.m. R73 and for nearly two hours in the ence to go to bed and for his wered. R73 stated the staff are necessary cares in the facility. S dated 10/6/15, identified cognitive impairment, and assistance from staff to 10/20/15, at 10:29 a.m. R35 aff worked short nearly all of had been times R35 would the bathroom but was not receiving timely assistance				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. BOILBING.			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 29	2 800			
	R123 had intact co	MDS dated 10/15/15, identified gnition, and required extensive aff to complete ADLs.				
	stated she had wait to the restroom, ca	10/20/15, at 12:20 p.m. R123 ted for over an hour to get help using her to, "Just use my stated made her, "Feel				
	R27 had intact cog	S dated 9/22/15, identified nition, and required extensive aff to complete ADLs.				
	stated she had wait her call light answe	10/20/15, at 10:24 a.m. R27 ted for over an hour to have red to receive assistance, and to have more staff to provide ents needed.				
	FAMILY COMPLAIR	NT'S ABOUT STAFFING:				
	member (FM)-G sta family member in the requesting staff assess waited, and waited, staff to respond. To occurrences of waited, answered, and FM- response times] conthey had been told they were "Adequated."	ated they had visited their ne past and used the call light sistance and "Waited, and " over twenty five minutes for here had been multiple ting for the call light to be G stated, "It [long call light ncerns me." FM-G stated the owners of the facility felt tely staffed," but stated she facility needed to add more nts with cares.				
		10/26/15, at 10:01 a.m. FM-H ed oral cares were frequently				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 30 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	E BOULEVAR O, MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	not being completed at the facility. The concurrence of the lack of assistant (Nacility needed more with cares. NA-G scomplain about the and lack of assistant NA-G stated the sconglain about the and lack of assistant NA-G stated the sconglain about the and lack of assistant NA-G stated the sconglain about the and lack of assistant NA-G stated the sconglain about the and lack of assistant NA-G stated the sconglain about the and lack of assistant NA-G stated the sconglain about the and lack of assistant NA-G stated the sconglain about the lack don't have enough residents." NA-G sinjured attempting to the state of the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents. The lack don't have enough residents at the lack don't have enough residents at the lack don't have enough residents.	d because of the lack of staff call light had taken over one d in the past, and was the weekends. S ABOUT STAFFING: 10/22/15, at 10:38 a.m. IA)-G stated she felt the estaff to assist the residents tated the residents often long call light response time nee they receive with cares. heduled baths and grooming is not always completed of staffing adding, "[staff] time to take care of the tated several staff had been on care for two assist residents ause, "There's not enough but." NA-G stated the facility staff they, "Are looking into it," provide the resident cares to an completed. 10/22/15, at 10:53 a.m. (HA)-A stated the nursing staff shave to wait for help for and HA-A will often walk by sidents asking, "Help me, help administration is aware of the able to assist residents with employees they are trying to	if	DEFICIENCY)		
	stated the staffing a	10/22/15, at 1:23 p.m. NA-I at the facility was, "Not good," uently only one or two NA's on				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 31 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/	26/2015
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
LAKE RI	DGE CARE CENTER	OF BUFFALO	E BOULEVARI O, MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	each hallway to pro The residents frequelights were not ansolack of staffing, "The care they should geomembers were injushelp for so long, an attempted to roll residents dusted the staffing was supposed to have for the residents dusted the residents dusted their schematic and the facility was supposed to have for the residents and on the received their schematic and attention. Naturesidents, and on the received their schematic and attention. Naturesidents in the staffing of the residents in the staffing of the administration have and attention. Naturesidents in the staffing of the administration have and attention. Nature and attention of the administration have and talked about however, nothing having enough staffing at the horrible," and resides tated there was free they are the staffing at the horrible, and resides the staffing at the horrible and staffing at	vide cares to the residents. ently had to wait, and call wered timely because of the ey [residents] don't get the et." NA-I stated several staff red because they waited for d nobody came, so they sidents in bed by themselves. 10/22/15, at 1:36 p.m. NA-C was "awful," adding the facility ave six or seven NA's to care ring the morning shift, but h only four NA's. NA-C stated skend there would be just two to care for all of the nat weekend, no residents duled bathing, and beds were				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 32 of 137

Minnesota Department of Health

AND DUAN OF CODDECTION INTERCATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313	D .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	and residents had to get their call light [staff] don't have tin administration had cares, but "they exp work done and only you guys [state sur During interview on licensed practical n "Not adequate," to needs, and she wa facility because she and felt it was being the lack of staffing as a result. During interview on stated she felt the f staff to provide the and residents had t and families voice fregarding the suffer poor staffing. LPN-dressing changes wourse did not have trying to help provice other residents. During interview on registered nurse (Ra "big issue" at the short of help and the overall. RN-A state because of the pool had never asked the to balance the work work work and the short of help and the overall. RN-A state because of the pool had never asked the to balance the work work work work work work work work	o wait for long periods of time is answered because "We ne," to answer them. The done nothing to help with pect" the floor staff to get the vicome onto the floor, "When	2 800			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	During interview on occupational therapist assistance could use more hel they hear from reside and waiting, "Way to answered. OT-K are aware of any action address the short something and anonymous member (SM)-A, see with concerns about SM-A stated the state and administration the past few days, surveyors] are here home after their shift were unable to complete the completed. Significantly and SM-A was told (DON) to sign the completed. Significantly upset," and with cares on the floonly being done, "buring an anonymous member (SM)-B staff on the residents. SM-B stadministration regal having enough staff baths, and grooming the sidents.	10/26/15, at 2:32 p.m. pist (OT)-K and occupational at (OTA)-J stated the floor staff p, and the biggest complaint dents was the lack of staffing poolong for [call] lights," to be and OTA-J stated they were not as being taken by the facility to taffing concerns. The stated they were not as being taken by the facility to taffing concerns. The stated they were presented to the lack of staff in the facility. The stated is the lack of staff in the facility. The stated were presented to the lack of staff in the facility. The stated in the facility was pulling in people to work the staff pool work and feel bad because they uplete their jobs and care for cares are just not good." In both the were scheduled for any two of them were completed by the director of nursing are sheets identifying they M-A stated that made her, stated administration helping for was not typical, and was because you guys [state with only two as floor to work and care for the floor to work and care for the	2 800			

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	10/2	.0/2013
_		310 I AKF	BOULEVAR			
LAKE KI	DGE CARE CENTER	BUFFALO BUFFALO), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	The facility LRCC (documents, which is staff working on the 10/19/15, to 10/23/document identified (Oasis, Lake View Northwoods), and go a staff members nawere they were school of the AM shift, no staff names identified work on the unit. Northwoods each is staff were schedule just one nurse and document identified used to identify staff. Northwoods had on names written in. So one nurse, and one providing care for the identified six of the identified six of the identified seven of identified seven of identified seven of identify staff, to be on the AM shift, had no NA displayer assigned to provide cares to the identified seven of identify staff, to be on the AM shift, had no NA displayer assigned to provide cares to the identified seven of identify staff, to be on the AM shift, to be on the AM shift, the control of th	Lake Ridge Care Center) displayed the names of the e floor for each shift, dated 15, were reviewed. The d each unit of the facility Lane, Mill Creek Bridge, and provided blank spaces in which ame was written to identify heduled to work. 10/19/15, the Oasis unit had natified as being assigned to Mill Creek Bridge and had open spaces identifying no led to work; and were left with one NA for each unit. The d six of the thirteen spaces ff, to be blank. 10/20/15, the Oasis unit again is identified as being assigned Mill Creek Bridge and ben spaces with no staff Both units continued with just in NA working on the floor he residents. The document thirteen spaces used to blank. 10/21/15, the Mill Creek Bridge ed, only having a nurse or care to the residents. The document the thirteen spaces used to blank. 10/22/15, the Lake View Lane	2 800			
		ified, and only one NA. Mill Northwoods again each only				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 35 of 137

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE BIDGE CARE CENTER OF BLIFFALO			BOULEVAR , MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 35	2 800			
	had one nurse and cares. The docume	one NA identified as providing ent identified six of the thirteen ntify staff, to be blank.				
	no staff name ident work on the unit, ar have a nurse identi	10/23/15, the Oasis unit had ified as being assigned to not the Lake View Lane did not fied. The document identified spaces used to identify staff, to				
	(DON) stated, "Rigistaffing. It is the driver stated, "We work we resources] all the tistaff." The DON are everything else that quality deficiencies concerns] There not be an issue if we floor." The DON st was well aware of the and the quality concinsufficient staffing staffing shortage be summer when study there were also eigomaternity leave as facility was still acceptated they had del later in the week well atter in the week were not receiving stated, "This is one staffing we were second week of Se	of p.m. the director of nursing on the now we are just stuck on the liver of all the other evils." She with corporate HR [human me to get and retain good olded, "I think that almost the we've identified [as potential are tied into it [staffing are so many things that would be had enough people on the lated the facility management the facility's staffing shortage cerns resulting from DON stated the facility's egan around the end of lents returned to college, and the facility staff who had left on well. The DON confirmed the lepting new admissions, but layed some admissions until layed some admissions until layed some admissions until layed concerns of residents who loaths or oral cares, DON of the things that is tied to doing great until the first or ptember We are supposed [but] have not had one since				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 36 of 137

Minnesota Department of Health

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 800 Continued From page 36 good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MINST BE PRECEDED BY FULL TAG CEACH DEPICIENCY MINST BE PRECEDED BY FULL TAG COMPLETED TAG COMPLETED TAG COMPLETED TAG COMPLETED TAG COMPLETED TAG COMPLETED TAG CROSS-REFERENCED NO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D			00714	B. WING		10/2	6/2015
LAKE RIDGE CARE CENTER OF BUFFALO SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 36 good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from	NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STATE ZIP CODE	10/2	.0/2013
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG	_		OF RUFFALO 310 LAKE	BOULEVAR	RD		
PREFIX TAG (EACH DEFICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 36 good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of residents) to determine the number of residents, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from	(V4) ID	SLIMMARY STA		1		ON.	(VE)
good wash ups." During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE DATE
During interview on 10/26/15, at 4:24 p.m. administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from	2 800	Continued From page 36		2 800			
administrator stated the facility staffing was determined based on the size of the building, and if they, "Have a lot of residents that have more needs." The facility does cut hours if they are down in census, and uses a formula (total number of hours divided by the number of residents) to determine the number of hours per resident, so being down one bed equals, "X amount of dollars." The administrator stated he had, "Certainly identified there is a problem" with staffing, and the focus was to hire and recruit new staff adding it had been the focus, "For a long time." A facility policy on staffing was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from		good wash ups."					
residents, employees and families. Interventions could be identified and implemented to remedy the insufficiencies identified, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		During interview on administrator stated determined based of they, "Have a lot oneeds." The facility down in census, an number of hours diresidents) to determine determined based of residents of dollars." had, "Certainly idenstaffing, and the foostaff adding it had be time." A facility policy on some was provided SUGGESTED MET The director of nursund/or revise facility related to sufficient personnel could be and procedures. Sevaluated for insufficienting evaluated for insufficienting in the insufficiencies in documentation mai could be developed results shared with Assessment & Asson-going compliance.	d the facility staffing was on the size of the building, and of residents that have more y does cut hours if they are ad uses a formula (total vided by the number of nine the number of hours per down one bed equals, "X The administrator stated he ntified there is a problem" with cus was to hire and recruit new been the focus, "For a long staffing was requested, but THOD OF CORRECTION: Sing or designee, could review y policies and procedures staffing. Responsible re-educated on these policies taffing patterns could be iciency, with input from es and families. Interventions and implemented to remedy dentified, with supporting ntained. An auditing system d and implemented, with the facility's Quality urance committee, to ensure ce.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	DE RUEFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 37	2 830			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			12/29/15
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility for assess and development for 1 of 3 residents R118 voiced complete demonstrated distressing change will the facility also fails wheelchair position	on, interview and document ailed to comprehensively interventions to reduce pain (R118) reviewed for pain, and essing pain during a wound nich resulted in actual harm. ed to provide proper ing for 1 of 1 residents (R57) gnificantly to the right side.		Corrected.		
	Findings include:					
	PAIN					
	identified diagnoses disease (PVD), oste of the right lower ex	sident Admission Record is including peripheral vascular eoarthritis in right hip, cellulitis stremity, non-pressure chronic leg non-healing with an				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 38 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LA	ADDRESS, CITY, S KE BOULEVAR LO, MN 55313	ID .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	infection, chronic parallel infection, chronic parallel infection, chronic parallel infection infection, chronic parallel infection infe	ain syndrome, and Trigemina ain). imum Data Set (MDS) dated R118's cognition was intact mited assistance for most ing (ADLs). The MDS not receive scheduled pain eived as needed (PRN) pain n-pharmacological in management. The MDS nade it difficult to sleep at r day to day activity. A rical pain rating scale identifics a nine out of 10 (a zero (0) rating scale of 0 = no pain, pain imaginable). Her pain equent, but did not include a of the pain even though the had one arterial or venous the MDS. essment (CAA) dated 8/24/1 ded assistance with all ADLs and decreased mobility from vanted to do as much for The CAA identified R118 has a right leg that was infected ain large amounts of fluid. The cate of the pain even though the ser right leg that was infected ain large amounts of fluid. The cate of the pain even that PRN Tramadol sic medication] relieves pain. It wells and repositioning. Staff nitor for pain and update MD	ed 10 5, d			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 39 of 137

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	at risk for uncontrol osteoarthritis and s extremity. The care state her pain was analgesic, or show pain. Interventions • Encourage R118 to numeric scale as a • Administer medica PRN, as ordered for Monitor R118 for creassessing her paractivities, etc During observation 11:30 a.m. R118 correlated to an open so She stated a routing been completed to pain she experience changes was excessing her pain she experience changes was excessing her pain medical dressing change the The ice packs, and subside almost, and like a grabbing pair through the ceiling. R118 was frequently and applying ice pather current pain levels a state of the pain she experience changes was excessing change the pain she pain medical dressing change the pain graphing ice pather current pain levels and applying ice pather current p	8. d 10/9/15, identified R118 was led pain related to tasis ulcer to her right lower plan goal was for R118 to decreased with the use of an non-verbal signs of decreased included the following: or report pain levels PRN, per a ble. It ions to R118, routine and or pain. hanges in comfort PRN, in as needed. It measures PRN, of cold, massage, diversional and interview on 10/21/15, at implained of unmanaged pain sore to her right, lower leg. It is defined the ed during these dressing sive, stating her pain "hits ated if the nurses think of dication before and after the ey will, along with some ice. pain medication at times, "Will d then all of the sudden it is a that almost sends me." During this conversation, by rubbing her right, lower leg locks to the area. R118 stated rel was, "down to a five [5] it reported a pain rating of 5 was	2 830	DEFICIENCY)		
	On 10/22/15, at 9:2	8 a.m. R118 was observed in				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 40 of 137

Minnesota Department of Health

IVIIIIIII	ta Department of Tie	ailii			,	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
		00714	B. WING		10/2	6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	STATE, ZIP CODE		
10 10 1	THO VIDEN ON OUT FIELD		E BOULEVAR			
LAKE RI	DGE CARE CENTER	OF BUFFALO	O, MN 55313			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
2 830	Continued From pa	ige 40	2 830			
	her room receiving	her morning medications				
		ical nurse (LPN)-F. Both				
		onfirmed she had just received	1			
		Gabapentin 300 mg, pain	•			
		nerve pain) and she typically				
		r pain pill to kick in," before he	r			
		as completed. R118 asked	•			
		a half hour to complete her				
		nd to bring an ice pack. At				
		tated, "[Her pain medication]				
		. when they start scraping,				
		t could stop the pain]." At				
		gathered supplies for R118's				
		While LPN-F was outside of the	Э			
	room, R118 was as	ked whether her pain				
	medications were h	nelping. She stated, "[It] never				
	does," and rated he	er pain a seven, out of 0-10				
		6 a.m. LPN-F returned to				
	R118's resident roo	m, completed her				
	preparations for the	e dressing change and was				
		reatment when R118 asked,				
		ck?" LPN-F stated she had				
		ne ice pack, but would bring it				
		completion of the dressing				
		loudly and firmly, "No. You ge	t			
		aid, "Okay, yes mam." LPN-F				
		ck and then began the				
		at 10:22 a.m., LPN-F removed				
		andage rolls) and ABD pad (a				
		essing used to provide				
		tion for large wounds). LPN-F				
		aerosol spray to slowly remov				
		(an absorptive dressing) and				
		olling and picking off the black	S			
		R118's open wound. While				
	LPN-F was removir					
		nent of the wound R118 was				
		d pulling away throughout the				
	nrocedure At 10.27	7 a m R118 had tears in her	1			1

Minnesota Department of Health

eyes, which she wiped with tissue paper that she

STATE FORM 6899 28WI11 If continuation sheet 41 of 137

Minneso	<u>ita Department of He</u>	alth					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL		MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	R: A. B	BUILDING:		COMPI	LETED
		00714	B. W	VING		10/2	6/2015
						10/2	0,2010
NAME OF F	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
I AKF RI	DGE CARE CENTER	OF BUFFALO	0 LAKE BOL		D		
	DOL OAKE CERTER	BU BUTALO BU	JFFALO, MN	I 55313			
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION	15	REFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	TIEGOE/TIOTTI OTTE	OO IDEIVIII TIIVA IIVI OTIIVIATION	'	TAG	DEFICIENCY)	107(12	
2 830	Continued From pa	ıge 41	2 8	330			
	held in her hand thr	roughout the dressing ch	ange.				
		g change R118 made LP					
		veral times, to take a bre					
		continuing. When R118					
		proceed with the dressin					
		take a deep breath, grim					
		ed with emotional tone to					
		ay." At 10:29 a.m., R118					
		tarting to burn." LPN-F a					
		t left enough time for her					
		n working. R118 replied, '					
		e to get something strong					
		as LPN-F applied the Ke					
		applied the ice pack to he					
		made LPN-F stop before	e the				
		er socks were applied,					
		eathe, and rest after the					
		as completed. LPN-F use	ed				
		ster another PRN pain	1! =				
		done 5mg 1 tablet, narco					
		R118. LPN-F administer					
		olied R118's stockinet an l at 10:37 a.m., left the ro					
		n as a nine, and during th					
		tated, "It's gotta hit 15,	ie				
		ready to pass out from the	10				
		., R118 was still holding					
		eg. At 10:45 a.m., R118					
		it (8) and stated her pain					
		line at this time. LPN-F d					
		er pain before, during or					
		e even though LPN-F					
		pain medication to R118.	_				
	During interview on	10/22/15, at 10:51 a.m.					
		ne verbal and non-verbal					
	indicators she obse	erved, which was a typica	aÍ 📗				
	reaction during her	dressing changes. LPN-	·F				
	reported R118's do	ctor and nurse practition	er				
	were aware of thes	e symptoms. LPN-F stat	ed				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 42 of 137 28WI11

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR			
		BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 42	2 830			
	offering Ultram first was not effective. L have ice at any time pain management time. She was not physician was, for the pain medicaitor trys to give her (R1 the dressing, so sh and "get her bearin when she is ready.	ement regimen consisted of , then oxycodone if the Ultram PN-F added, she could also e and this has been the same regimen for R118 for some sure what the rational of the not making further changes to a regimen. LPN-F stated, She 18) time when she removed e (R118) can take a breath gs" and will then continue				
	directed the following management regiments. Wound treatment allower extremity- clear cover with ABD particles and PRN. Gabapentin 300 mperipheral neuropa. Ultram 50 mg, even chronic pain syndromody. Oxycodone 5 mg, not relieved by Ultram 50 mg, not relieved	ng wound treatment and pain nen: to stasis ulceration on right canse wound, apply Silversorb, and Kerlix, change dressing illigrams (mg), twice daily for thy/ polyneuropathy. ry four hours PRN for pain, for ome. every four hours PRN for pain am, for chronic pain syndrome.				
	8/17/15, to 10/26/18 R118's New Patient Examination, comp (MD)-A and dated so osteoarthritis affect hip, with residual parthroplasties. The her pain. On 8/24/15, nurse phad complaints of patient with dressing change.	hysician progress notes from 5, identified the following: t History and Physical leted by medical doctor 9/3/15, noted she had ing her knees, shoulder and ain post knee and hip report did not further address practitioner (NP)-A noted R118 pain to her right lower extremity ges.				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 43 of 137

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR			
	T	BUFFALO	, MN 55313		201	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 43	2 830			
2 630	R118's right lower litreatments. NP-A n will add oxycodone pain." On 9/23/15, a Wou History and Physicathe anteromedial poleg. This measures [centimeters]. The fibrin and 40% pale and I am unable to it. It does not appeatried to dress the patient with lodosorb in an but the patient was painful She did rehere and once her then dressed" On 10/8/15, NP-A a lower leg ulcer. NP-says, 'I'm ok,' but fr LE [lower extremity [Complains of] pain to Monticello Woun nothing.' She is ver allow to be put on F waiting for dressing no change to the w continue with antibit through 10/12/15. On 10/19/15, NP-A room visit was revia address R118's stat No further assessme pain management of progress notes.	eg and reviewed the dressing oted, "Discussed pain control for mod [moderate]/severe and Care/ Hyperbaric Medicine al noted, "There is a wound on ortion of [R118's] right lower 11 x [by] 12.5 x 0.1 cm wound is about 60% yellow red. It is very tender to touch do any sort of debridment on ar to be infected I initially atient's wound with Medihoney; at developed a lot of discomfort nclination had been to treat it attempt to control drainage afraid that that would be receive a dose of oxycodone pain got better her wound was addressed R118's chronic right A noted, "Resident today owning and awaiting R [right] dressing [change]. C/o to R LE. Refuses to go back d Clinic- 'They don't know y particular about what she will R LE wound looks unhappylichange]." The note directed ound treatment and to otic treatment for cellulitis	2 830			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 44 of 137

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Administration Rec 10/25/15, identified medications were a extremity and leg portage. The September 20 a total of 103 doses She took 68 doses effective 42 of 68 of 14 of 68; not effective was not identified for R118 had 35 doses September 2015, which was not identified for R118 had 35 doses September 2015, which was not identified for R118 had 35 doses September 2015, which was not identified. The October 2015 administered 100 dright, lower extremit doses of Ultram 50 of 49 opportunities; and not effective 6 R118 had 51 doses October 2015 which opportunities; slight effective 5 out of 5 identified, 1 out of 8 Review of the EMA from September to correlate with R118 the dressing chang documented.	ord (EMAR) from 9/1/15, to the following as PRN pain administered for right, lower ain. 15 EMAR identified R118 took of PRN pain medication. of Ultram 50mg, which were pportunities; slightly effective ive 2 of 68, and other, which or 1 of 68 opportunities. of PRN oxycodone 5mg in which was effective 14 out of ightly effective 3 out of 35; and it identified 3 out of 35, EMAR identified R118 was loses of pain medication for ty leg pain. She took 49 mg, which was effective 17 out of 49; out of 49 opportunities. of PRN oxycodone 5mg, in h was effective 34 out of 51 ty effective 11 out of 51; not 1 and other, which was not 51 opportunities. R PRN administration times October 2015, did not its dressing changes, because es were not consistently	2 830			
	of PRN pain medic	was administered 203 doses ation, taken in 55 days, doses of PRN pain medication				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 45 of 137

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I AKE RIDGE CARE CENTER OF BUFFALO			BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	each day, along wit 300 mg twice a day experience significate changes. Review of R118's n 8/17/15, through 10 of pain for R118: On 8/24/15, at 10:1 "Changed dressing hour later Resident Writer asked if a patoo much and it need asked for it to be tad dressing cleaned Bacitracin with nonwith ABD and wrap not have any further that she receive so that won't burn." On 8/27/15, at 1:09 rates pain 8/10;p 'burns' refused to heing sent to updat doctor]." On 8/27/15, at 10:2 dressing changed macerated et [and] claims the wound swashing wound. Recon her D/T [due to] On 9/6/15, at 10:48 c/o pain in RLE drequest; cool cloth has been elevated; when may have pron 9/7/15, at 1:39 proted, "[R118] refused.	h her scheduled Gabapentin R. R118 continued to ant pain with her dressing ursing progress notes from 0/26/15, identified complaints 8 p.m. LPN-G noted, on lower right leg About an had c/o a 'burning pain.' ain pill would help or if it was eded to be taken off? Resident ken off. Writer took off wound and only applied estick dressing then covered ped with Kerlix. Resident has r c/o pain but is requesting mething else on the wound a.m. LPN-D noted, "[R118] her resident alginate dressing ave on skin;communication e PMD [primary medical 3 a.m. LPN-F noted, "Leg . Area continues to be red, tender to the touch Resident pray hurts her when use for esident refused it to be used reported pain." p.m. LPN-D noted, "[R118] ressing removed per [R118's] applied with some relief; leg will reassess in one hour in pain medication." o.m. registered nurse (RN)-C sed to have dressing put on in art hurting again [R118] is	2 830			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 46 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAK	DDRESS, CITY, S E BOULEVAR O, MN 55313	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	On 9/8/15, 2:28 p.n the on call MD/NP aresident's wound on to let staff place a corders." On 9/8/15, 11:10 p. pain to RLE. [R118] prn pain medication call physician said Tylenol. Will adminimonitor." On 9/13/15, at 12:2 [R118] does c/o paic change PRN pair at this time." On 9/19/15, at 1:12 c/o 7/10 pain right I relieved with prn Trdressing changed to 0n 9/23/15, 10:39 pmedicated as directly burns so bad who On 10/8/15, at 2:09 continues to c/o pachanges et PRN pawhen 2 different Procloser together. Re Area on leg measur macerated with sor change when NP won 10/12/15, 2:27 pcontinues to c/o pachanges to c/o pachanges to c/o pachange when NP won 10/12/15, 2:27 pcontinues to c/o pachange when NP won 10/12/15, 2:27 pcontinues to c/o pachange when NP won 10/15/15, at 12: "Treatment completreatment is being of the staff of the complete treatment is being of the staff of the complete treatment is being of the call of the complete treatment is being of the call of	n. LPN-B noted, "Writer called and left a message regarding her leg. Resident is refusing dressing on her leg per m. LPN-C noted, "[R118] c/o is unable to have any more of for another 2 [two] hours. On the dister Tylenol and continue to the ster Tylenol and the ster				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 47 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00714	B. WING		10/2	26/2015
NAME OF PROVIDER OR SUPPLIER LAKE RIDGE CARE CENTER OF E	BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAR D, MN 55313	TATE, ZIP CODE D		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
rates RLE pain 7/10, so pack and PRN pain me During interview on 10/ nursing assistant (NA)- her legs and she had so crying." NA-A stated had and/or has complained NA-A stated she told the R118 complained of an see if she could be give NA-A stated the pain me "somewhat effective, [beffective]." During interview on 10/ registered nurse (RN)-H was mainly in her right an open area. RN-H state improving, but was take review of the EMAR, Referring was typically around prior to receipt of her Pereported R118's physicial Thursday and was respensure her pain manage sufficiently effective. Reference her pain manages ufficiently effective. Reference her pain manages of the physicial commenting on her pain progress notes, on 10/8 had attended a wound after 9/23/15, because did not want to go there she had spoken to R11 recently as 10/14/15, as satisfaction with her paudon inquiry as to R118 pain, RN-H replied she	o.m. LPN-D noted, "[R118] omewhat relieved with ice edication." (26/15, at 10:42 a.m. A stated, R118 has pain in een her "pretty upset and as seen R118 in pain of pain to her almost daily. The facility nurses when addor appeared in pain, to en any pain medication. The edications seemed out] never 100% (26/15, at 2:32 p.m. Hereported R118's pain lower leg, where she had atted the area has been ing a long time. Upon N-H reported R118's pain und an 8 (0-10 pain scale) PRN pain medications. She ian was at the facility every consible for monitoring to gement regimen was N-H stated the most recent and nurse practitioner in was the physician's 8/15. RN-H reported R118 clinic, but stopped going she was very upset and a anymore. RN-H stated 8 about her pain, as nd she had indicated in management regimen.				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 48 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00744	B. WING		40//	00/0045
		00714			10/2	26/2015
NAME OF PROV	VIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RIDGE	E CARE CENTER	OF BUFFALO	E BOULEVAF O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
dre ma sta res ch dre kn ex sh mu co NA ha un loc me pa we ma R1 co as co Du dir co fre me ch thr do in fro an dre loc dis	anagement reginated the nature of sult in some, inevanges. However essing change of owledge of R118 treme. RN-H state is having that ruch pain." RN-H nocerns for R118, As. RN-H stated, we updated the pain and the pain and the pain and the pain should and the facility of their sole pain and their sole pain the pain the pain the pain the pain their sole pain and their sole pain their sole pain and their s	but believed the current pain nen was effective for her. She f R118's wound was going to vitable pain during dressing, when told of the observed in 10/22/15, RN-H denied is having reactions to that ted, "If she [R118] is saying much pain, she is having that denied any reports of pain from the facility nurses or she expected staff would obysician if/when they identified as the physician could have in increase in R118's pain stated R118's use of the ice owever, "If that was what we that would not be a sufficient or pain." RN-H confirmed, I have been reassessed. RN-H ty used section J of the MDS issessment, which was only				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 49 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7t. Bolebiito.			
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	R118 was first adm dressing changes of they were presently never seen R118 c and upon discussic change (10/22/201 that kind of responshad completed or changes. The DON discomfort with this if R118 had demon as identified in the expected the nurse medical record and getting some different her. Although R118, had progress notes that had nurses and nur R118 in pain, either or other times durin Gabapentin 300 mg scheduled pain me PRN for pain and of moderate to severe Gabapentin 300 mg in the morning of 10 oxycodone 5 mg aft completed. Even the funmanaged pain distressing pain du The facility did not developed an appreinterventions to assiresulted in actual h.	were much more painful than w. The DON stated she had ry during a dressing change on of the observed dressing 5), she denied having seen see from R118 any time she observed her dressing I stated she expected some a type of dressing change, but strated significant signs of pain 10/22/15 observation, she is to document this in the I see what they could do about ent analgesic medications for during her dressing changes in the day. R118 only received in the dication, and Ultram 50 mg expands a day, for a routine dication, and Ultram 50 mg expans. R118 only received the grown to her dressing change of prior to her dressing change of prior to her dressing change was a lough R118 voiced complaints in, and demonstrated aring a wound dressing change. Comprehensively assess and opriate pain management sist in reducing her pain. This arm for R118.	2 830			
		d nursing to check physician esident required an analgesic				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 50 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
(00714	B. WING	· · · · · · · · · · · · · · · · · · ·	10/2	6/2015
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF BUR	FALO	E BOULEVAR D, MN 55313			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830 Continued From page 50 prior to completion of dres administer any analgesic rathe policy did not further a management during dress policies regarding pain madressing changes were readditional policies were provided in the policies and polic	medication as ordered. address pain sing changes. Facility anagement with quested, but no ovided. NING d 9/22/15, identified mobility, and required activities of daily living assessment dated contractures, and 57's care plan dated ons in mobility related to directed staff to refer to therapy as needed. d dated 9/13/15, esident on wheel chair right." A Resident 5, indicated R57 was ld "drift off, leaning to a 10/19/15, at 8:16 p.m., chair. She appeared to resting on her right on 10/20/15 at 9:58 arved sitting in her wheel side. On 10/21/15, at g to her right side in her resting on her tray 5 p.m., R57 was seel chair, leaning to her				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 51 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/26/	2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
LAKE R	DGE CARE CENTER	OF RUFFALO	E BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	chair. Although R57 there were no supp support her trunk the During and interview NA-B stated R57 re time, that's why we further stated R57 " side, not sure why te During an interview occupational therap R57 was recently gi her wheel chair. Of referral "about a mo picked up for ongoi size was appropriat fatigued. During an interview NA-T stated, R57 is get her up for brea in her wheel chair. I to lean a little but he for the past few wee During an interview LPN-H stated, som getting her (R57) to will place a pillow un uncomfortable posi that." LPN-H further her second chair, a lateral supports or i at high risk for fallin she is always leanir stated, R57 had bee	orts noted in her wheelchair to nat prevented her from leaning. w on 10/23/15, at 11:32 a.m., fuses to lay down a lot of the put pillow by her head. NA-B has always leaned to the right hat is." on 10/23/15, at 11:48 a.m., by assistant (OTA)-J stated iven a right lateral support for TA-J stated R57 was seen for a point or so ago," but was not ng therapy. He felt R57's chair the but that (R57) was more on 10/26/15, at 1:53 p.m., as like that "all the time," they kfast and then she falls asleep NA-T further stated, she used ar leaning has been going on				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o. ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WI	ING		10/2	26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO 310	REET ADDRESS D LAKE BOU FFALO, MN	LEVAR	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PR	ID EFIX 'AG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	During an interview occupational therap they had received a because of her lear supports. They also down if tired and list negative outcomes the time of the refer lateral support was amount of assistant and be able to prop OT-K and OTA-J fur leaning that bad who current positioning have been referred evaluation. A policy addressing requested, but was SUGGESTED MET The director of nursuand/or revise facility related to pain man and coordination of Responsible persor these policies and pidentified in the defifor the needs identified in the defifor the needs identified in the defifor the needs identified auditing system could be evaluated management, proportion of care with outside auditing system could implemented, with a Quality Assessment ensure on-going control of the contr	on 10/26/15, at 2:32 p.m pist (OT)-K and OTA-J state referral in September for ing and gave her a later to recommended she (R5 ted the potential for several in September 2015, the providing R57 with the ceshe needed to sit up related the stated, R57 was "in the stated, R57 was "in the stated, R57 was "in the was a change and she sit back to therapy for an appropriate position of the provided. THOD OF CORRECTION sing or designee, could respond to the provided and procedures agement, proper position care with outside providence could be re-educated procedures. The individuation of the proper position of the provided service providers. An all the developed and results shared with the fatta & Assurance committed in the procedures and procedures and procedures and procedures agement, proper position and coordinate providers. An all the developed and results shared with the fatta & Assurance committed in the providers and procedures are positioning and coordinate and coordinate committed and the providers are providers.	ated, or R57 al si7) lie eral c. At he ight nair. ever her hould was sing ers. d on ial(s) sed exit in ation acility's e, to	30				
	(14) days.	R CORRECTION: Fourte	een					

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD	<u>/2015</u>
210 LAVE DOLLI EVADO	
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETE DATE
DEFICIENCY)	12/29/15

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 54 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING	·····	10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	contact with the res	sident. Soiled linen and moved immediately from	2 840			
	by: Based on observation review, the facility for completed for 2 of assistance with toil residents (R126) reliving (ADLs) and with for their care.	ent is not met as evidenced ion, interview and document ailed to ensure bathing was 5 residents (R45, R19), and eting was provided for 1 of 5 eviewed for activities of daily who were dependant on staff		Corrected.		
	had intact cognition assistance from sta	G: dated 8/11/15, identified R45 a, and required physical aff to complete her bathing. 10/22/15, at 1:46 p.m. R45				
	stated she does no bath because of the Further, R45 stated consistently makes like to have her bat Facility Lakeside O 9/14/15 to 10/21/15 were constructed be week, and staff were which day they recename on the form a	t always receive her schedule e facility being short staffed. I not receiving her bath her "angry", and she would hing completed. asis Bath Records dated were reviewed. The records y identifying the days of the re to identify a resident on eived their bath by writing their and initialing next to it when				
	completed. R45's	name was identified on the or three weeks there were no				

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00714		B. WING		10/3	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO	310 LAKE	DRESS, CITY, S BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 840	staff initials identifies he received bathin record initials were When interviewed of NA-C stated R45 end they were sometime of staff to complete During interview on stated she was not her baths as schedisurprise me." Furth have been given her R19's quarterly MD R19 had intact cognifrom at least two staff to because there was facility. Further, R1 receive all of her some important to her. A facility Mill Creek List dated 8/3/15 to scheduled for a bat was constructed by week, and staff were which day they recename on the form a completed. Howey	ed next to her name to ag. The spaces provide left blank. In 10/22/15, at 1:36 purity provided her showers, but them. 10/23/15, at 11:59 a.m. aware R45 was not resuled, but added it "wounder, RN-A stated R45 ser baths as scheduled. S dated 9/29/15, identification, and required assaff to complete her bath and the ser bath and the state of the state of the ser bath and the state of the ser bath and the ser bath and the state of the ser bath and the ser bath and the state of the ser bath and the ser bath by writing the ser bath b	m. ut added to a lack n. RN-A ceiving uldn't should ified sistance thing. R19 h twice t times ff at the coas "very" and Vital 19 was sting the conn g their when	2 840			
	When interviewed of	on 10/22/15, at 1:36 p.i	m.				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 10/2	0,2010
LAKE RI	DGE CARE CENTER	OF BUFFALO 310 LAKE	BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	Continued From pa	nge 56	2 840			
	NA-C stated R19 e some have been m staff available to co	njoys her baths, but added hissed because there were no emplete it. 1 10/23/15, at 11:59 a.m. RN-A tion was for staff to complete				
	A facility policy on bathing was requested, but none was provided.					
	LACK OF TIMELY	PERICARE:				
	R126's admission Minimum Data Set (MDS) dated 9/25/15, identified R126 had intact cognition, required extensive assistance for toileting and personal hygiene, and was continent of bowel.					
	had an alteration in decreased mobility bowel. Further, the complete, "Pericare [morning] and HS [care plan did not id	ated 10/12/15, identified R126 I his elimination related to I, but remained continent of I care plan directed staff to I with assist of 1 with am I hour of sleep] cares." The I entify if or when pericare I ed for toileting not associated Is.				
	stated he was deperience after havin however he did not assistance with this stated his bottom was too long, so he would be pan, and place himself to prevent to	a 10/20/15, at 3:22 p.m. R126 endent on staff for help with a a bowel movement, always receive timely s. R126 used a bed pan, but yould get sore if he sat on it for all remove himself from the enewspaper underneath of the bed linens from becoming ted for staff assistance with				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 57 of 137

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, MN 55313	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 840	Continued From pa	ge 57	2 840				
	nursing assistant (NR126 with toileting noticed feces soiled before. NA-A state using it as a barrier becoming soiled who During interview on registered nurse (RR126 was using the bowel movement with pericare's.	on 10/26/15, at 10:27 a.m. NA)-A stated she had assisted and pericare's before, and d newspaper on his bed d she was unaware R126 was to prevent the linens from hile waiting for staff assistance. 10/26/15, at 2:18 p.m. N)-H stated she was unaware a newspaper after having a while he waited for assistance					
	A letter submitted post survey exit dated 10/28/15, authored by NA-T noted, "A couple of times [R126] would have his light on but he put the newspapers under him prior to the [NAs] arrival. He had the bedpan within reach and put himself on bedpan, notifying staff only when he was done."						
	10/30/15, authored to use newspaper utold him he didn't ne	ost survey exit, dated by NA-D noted, "[R126] chose under himself even though I eed to do that and we would it soiled. He continued to put him."					
	A facility policy on to requested, but none	oileting and pericare was e was provided.					
	The director of nurs and/or revise facility related to the provis activities of daily liv personnel could be	THOD OF CORRECTION: sing or designee, could review y policies and procedures sion of assistance with ing (ADLs). Responsible re-educated on these policies ppropriate provision of ADL					

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 58 of 137

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00714	B. WING		10/2	6/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 840	services could be reindividual(s) identifications apporting docume residents could be provision of ADL secould be developed results shared with Assessment & Asson-going compliant	e-assessed for the ed in the deficiency, with entation maintained. Other evaluated for appropriate ervices. An auditing system and implemented, with the facility's Quality urance committee, to ensure	2 840				
2 860	Proper Nursing Car Subp. 2. Criteria for proper care. The cadequate and prope. Per care and attringernails and toe trimmed. This MN Requirem by: Based on observative review, the facility for the property of the care of th	or determining adequate and criteria for determining er care include: cention to hands and feet. chails must be kept clean and ent is not met as evidenced ion, interview and document ailed to ensure nail care was	2 860	Corrected.		12/29/15	
	needed staff assist living (ADLs. R5's quarterly Mining 9/15/15, identified Frequired extensive complete her personal During observation	5 residents (R5, R64), who ance with activities of daily mum Data Set (MDS) dated R5 had intact cognition, and assistance from staff to onal hygiene. on 10/20/15, at 9:16 a.m. R5 bliner chair in his room. R5					

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 59 of 137

Minnesota Department of Health

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00714	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAR MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 860	had visibly long fing dark colored substanails. R5 stated he everybody can cut the preference would be 10/22/15, at 9:01 and dirty fingernails on the When interviewed on the interviewed on the interviewed cares or as care was to be combathed as and stated the clean underneath." Were unaware of arlong, dirty fingernails out." Further, LPN-on nursing staff for should have been the bath day. When interviewed or registered nurse (Rassistance to compshould have been to should be taken candone."	gernails on both hands with a ance underneath several of the was diabetic so "not them", but added his e to have shorter nails. On m. R5 continued to have long, both hands. on 10/22/15, at 1:53 p.m. JA)-T stated R5 seldom sistance from staff, and nail apleted on residents scheduled p.m. NA-T observed R5's by were too long, and "not very Further, NA-T stated they by preference of R5 to have is and they should be trimmed. 10/22/15, at 2:33 p.m. Jurse (LPN)-A observed R5's is and stated "they need to be A stated R5 was dependent his nail care, and his nails rimmed and cleaned on his cleaned and trimmed, "[They] are of when they get their bath is dated 9/15/15, identified cognitive impairment, and assistance from staff to	2 860			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 60 of 137

Minnesota Department of Health

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 860 Continued From page 60 was seated in a standard wheelchair in his room.	(X3) DATE SURVEY COMPLETED	
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 860 Continued From page 60 was seated in a standard wheelchair in his room.	/2015	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 860 Continued From page 60 was seated in a standard wheelchair in his room.		
was seated in a standard wheelchair in his room.	(X5) COMPLETE DATE	
R64 had visibly long fingernalis with several nails having a dark colored substance underneath several nails. R64 stated he preferred to have shorter kept nails adding they "could use a clip." On 10/22/15, at 9:04 a.m. R64 was seated in his wheelchair outside his room, and continued to have long, dirty fingernails on both hands. When interviewed on 10/22/15, at 1:53 p.m. NA-T stated R64 had never refused cares or staff assistance to their knowledge. At 2:03 p.m. NA-T observed R64's nails and stated they were "very long" and should be cleaned and trimmed. During interview on 10/22/15, at 2:33 p.m. LPN-A observed R64's nails and stated they should have been cleaned and trimmed on his bath day. When interview on 10/23/15, at 11:23 a.m. RN-A stated R64 had no desired preference to have long, dirty fingernails and they should have been cleaned and trimmed on his bath day. A facility policy on grooming and nail care was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to the provision of nail care. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of fail care. Services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other		

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 61 of 137

Minnesota Department of Health

STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF			SURVEY LETED
		00714	B. WING 10/2		6/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 61	2 860			
	Quality Assessmen ensure on-going co	t & Assurance committee, to mpliance.				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			12/29/15
	have a continuous management to recunnecessary use or comprehensive reshome must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident with receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ig catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to it infections and to restore as er function as possible.				
	by: Based on observati review, the facility f assess and develor urinary continence reviewed for urinary Findings include: R64's quarterly Min	ent is not met as evidenced on, interview and document ailed to comprehensively o interventions to promote for 1 of 3 residents (R64) y incontinence. imum Data Set (MDS) dated R64 had moderate cognitive		Corrected.		

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, SE BOULEVARD, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	impairment, require toileting and was, "A R64's Nursing Obse dated 9/18/15, iden incontinent" of blade of when he needs to The assessment dirtype of a toileting primplemented for R6 incontinence. R64's care plan data an, "Alteration in eliweakness following "Aware of the need the care plan direct request", and, "Morpatterns and reasserequest or as needed During interview on nursing assistant (Nathe bathroom when but has noticed R64 urine" lately. Furthers et toileting scheduring observation a.m. R64 was assist NA-F removed a vispad from R64, and R64, "Had the wronhave had an "extra on during the night skin from being incoremoved incontiner R64 was typically in when assisted to the	ed extensive assistance with Always incontinent" of bladder. ervations 3.0 Assessment tified R64 to be "always der, and R64 was "not aware o use the toilet appropriately." d not identify if any or what rogram needed to be 64, to decrease R64's red 9/21/15, identified R64 had mination r/t [related to] hospitalization", but R64 was, to void/defecate." Further, ed staff to, "Toilet per nitor for changes in elimination ess quarterly and prn [per ed]." 10/22/15, at 9:43 a.m. IA)-T stated he helps R64 to he requests as care planned, 4 to be "more incontinent of er, NA-T was unaware of any				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 63 of 137

PRINTED: 12/10/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00714 10/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 1 0 Continued From page 63 2 9 1 0 when he needed to use the restroom, so she helped him "every two hours" to the restroom. During interview on 10/23/15, at 11:34 a.m. registered nurse (RN)-A stated R64 was able to voice his need to use the restroom. "Most of the time", and should be helped with toileting every two hours. R64 should not be incontinence of urine, "More than a couple times a day," with his toileting ability, and the assessment completed on 9/18/15 should have identified a toileting program for R64 to promote continence. Although R64's assessment identified him as "always incontinent" of bladder, and R64 was "not aware of when he needs to use the toilet appropriately." There was no indication if R64 needed a scheduled toileting program, or was a check and change (no attempts to place on the toilet) even though R64 had been using the toilet. and NA-F stated he did have some continent voids. A facility policy on urinary incontinence was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who are incontinent of bladder to assure they are receiving the necessary

Minnesota Department of Health STATE FORM

incontinence.

(21) days.

treatment/services to assist with continence status. The director of nursing or designee, could conduct random audits of the delivery of care; to

ensure appropriate care and services are implemented; to reduce the risk for bladder

TIME PERIOD FOR CORRECTION: Twenty-one

Minnesota Department of Health

AND BLAN OF CORRECTION \ \ \ IDENTIFICATION NUMBER:					SURVEY LETED	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21330	Continued From pa	ge 64	21330			
21330	Routine & Emerger	•	21330			12/29/15
	must be referred fo unless the resident examination within admission. B. After the ininursing home mus resident wants to seany necessary help at least an annual bannual dental check one year from the examination or with	ental visit. Tays after admission, a resident of an initial dental examination has received a dental of the six months before tial dental examination, a set ask the resident if the see a dentist and then provide to make the appointment, on the sais. This opportunity for an of the initial dental of the initial dental of the within the six months				
	by: Based on observati review, the facility for recommendations with manner for 1 for 3 r	ent is not met as evidenced on, interview, and document ailed to ensure dental were acted upon in a timely residents (R85) reviewed for who needed new dentures.		Corrected.		
	Findings include:					
		imum Data Set (MDS) dated 35 had intact cognition.				
	R85 was seated in had visible missing	on 10/20/15, at 10:10 a.m. his room in a wheelchair. R85 teeth on his lower palate, and noved in his mouth while he				

Minnesota Department of Health

AND BLAN OF CORRECTION \ IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21330	spoke. R85 stated "Worn down", and v R85 stated at times because of the loos like to have them lo R85's Patient Progr identified R85 had b visits the facility. TI [patient] has full upp partial denture is no remaining lower tee gumline Both full extreme occlusial w on both for retention upper only" The plan of, "Will tx [treat lower dentures and	his dentures were getting, were, "Not effective anymore." he had trouble chewing food the fitting dentures, and would oked at by a dentist. The sees Notes dated 8/11/15, the dentist identified, "Pt the dentist identified, "Pt the dentist identified, "Pt the dentist identified, "Pt the dentist identified, and lower partial. Lower of anchored on any teeth as all of the are fractured off at the supper and lower partial have the dentist identified a treatment at plan full upper and full if pt decides to proceed, we surgeon for the extractions of	21330			
	identified R85, "w recommends that re lower roots extracte then have a new ful made will discuss resident and if he consult to pursue identified in R85's in follow up completed requested by R85 and During interview on registered nurse (R of the dental recommendation	10/26/15, at 10:05 a.m. N)-A stated she wasn't aware mendation for R85 to have a stated the facility social followed up on the consult				

6899

PRINTED: 12/10/2015

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING __ 00714 10/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **310 LAKE BOULEVARD** LAKE RIDGE CARE CENTER OF BLIFFALO

LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
21330	Continued From page 66 During interview on 10/26/15, at 10:22 a.m. licensed social worker (LSW)-A stated she was aware R85 had been requesting new dentures since "he came" (admitted to the facility), but LSW-A stated she was not aware of the recommendations by the dentist on 8/11/15, for R85 to be seen by an oral surgeon. LSW-A stated any follow up completed would have been documented in the progress notes, and she was unable to locate any documentation it had been addressed. During a follow up interview on 10/26/15, at 11:21 a.m. LSW-A stated she had just spoken to R85 and he would like to pursue getting new dentures made, so LSW-A stated she would assist the resident to make a dental appointment. A facility policy on dental consultation was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to dental services. Responsible personnel could be re-educated on these policies and procedures. Appropriate provision of dental services could be re-assessed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate provision of dental services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Thirty (30)	21330	DEFICIENCY				
	days.						

Minnesota Department of Health

AND BLAN OF CORRECTION TO TRANSPORT TO AN OF CORRECTION OF THE CATION OF					E SURVEY PLETED	
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER	OF RUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 67	21375			
21375	Program Subpart 1. Infection	O Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection	21375			12/29/15
	sanitary environme	signed to provide a safe and nt. ent is not met as evidenced				
	by: Based on observati review, the facility facontrol practices ar spread of infection	on, interview, and document ailed to implement infection and procedures to prevent the for 1 of 3 residents (R118) wound dressing change.		Corrected.		
	Findings include:					
	identified diagnoses lower extremity, nor lower right leg with	sident Admission Record s including cellulitis of the right n-pressure chronic ulcer of unspecified severity- seudomonas in wound.				
	dated 8/24/15, iden	Minimum Data Set (MDS) tified R118's cognition was limited assistance for most ing (ADLs).				
	nurse (LPN)-F was dressing change to right lower leg. LPN supplies, laid a clea beneath R118's righ seated in her wheel between the towel a	observed completing a R118's open wound to the N-F gathered the necessary an towel directly on the floor nt foot, while R118 remained lchair. No barrier was placed and the floor. After washing ying gloves, LPN-F removed				

Minnesota Department of Health

winnesc	ota Department of He	aitn				
AND DIAN OF CODDECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE DI	DOE CARE CENTER	OF BUEEN 310 LAKE	E BOULEVAF	RD		
LAKE KI	DGE CARE CENTER	BUFFALO	O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ıge 68	21375			
	bandaging), remove of a small scissors, absorption pad overight lower leg. The were discarded in the scissors were set at ouse Simply Salin loosen a Silversorb dressing) from R11 debris and slough of from the wound and R118's foot. LPN-F debris away from the wash to break it up wash, mixed with deprise and silversorb dressing the wound applied new dressing the wound applied new dressing the wound applied new dressing the wound, then plate footrest of her wheelinward and draped She picked up her silversor behind R118, next to rested the scissors covered the top of I was placed betwee mat. She then react stand drawers. At the wheelchair forw so LPN-F could open her supplies. The ri R118's wheelchair forward of the floor the	t (a stretchy fabric used for ed the soiled dressing with use, and then removed the er the open wound to R118's dressing and absorption pad the trash, but the stockinet and aside, while LPN-F proceeded the Wound Wash to soak and to (antimicrobial wound 8's open wound. Dark brown was observed to break free d drip onto the towel beneath removed the dark brown the wound using the saline and removed it. The saline lebris/ slough, was dripping ower leg, onto the towel. The baked through, in a circular by right heel, approximately six at 10:27 a.m., LPN-F and washed her hands after and. At 10:29 a.m., LPN-F and a clean stockinet to aced R118's foot back onto the elchair. LPN-F folded the towel it over the lined garbage bin. Supplies and stepped back to the night stand. LPN-F atop a Dycem mat, which R118's night stand. No barrier on the scissors and the Dycem shed to open one of the night his time, R118 self-propelled ward approximately 18 inches, en the drawers and put away ight front and back wheels of was observed to roll over the at became soiled by the elpn-F had finished				

Minnesota Department of Health

accessing the night stand drawers, R118

STATE FORM 6899 28WI11 If continuation sheet 69 of 137

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BOILDING.	A. BOILDING.			
	00714	B. WING		10/2	6/2015	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
LAKE RIDGE CARE CENTER O	DE RIJEFALO	BOULEVAR , MN 55313	D			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
same area and return At 10:37 a.m., LPN-I disinfectant wipe from cart and wiped the flatowel was placed, the sanitizing wipe from the scissors clean and stand drawers. LPN-mat where she had a R118's night stand. The area and the original been set aside at thin metal bar of R1 behind the right foot wheel. The stockined circular, light to dark drainage. During interview on LPN-F stated it was towel directly on the that drip to the floor, dressing changes. Lace Clorox disinfectant with the floor after the dreshed did not realize R through the soiled and disinfected it. LPN cleaning up the suppressockinet from the scand it was R118's prestockinet and re-use through the laundry, about placing the so Dycem mat on R118 had to put it somewhall tried to keep clean dressings and	heelchair back through the rned to her original position.	21375				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 70 of 137

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	10/26/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	ΩΕ ΒΠΕΕΔΙ Ω	BOULEVAF), MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21375	where she had set wipe. During interview on registered nurse (R control coordinator, sanitizing wipes she supplies LPN-F gat change. RN-B state beneath the towel, the flooring immedi come in contact wit have been sanitized stated a barrier sho between the soiled stand, and the soiled stand, and the soiled stand, and the soiled stand, and the soiled stand Responsibilities the facility's Infectional Responsibilities the facility's commit developing training personnel on infect procedures. The confort ensuring the face environment, with a established infection precautions. The facility include the use of palong with the decoequipment when expected to infection and/or revise facility related to infection dressing changes.	ge 70 the scissors with a sanitizing 10/26/15, at 2:24 p.m. N)-B, the facility's infection stated disinfectant and ould have been amongst the hered for R118's dressing ed without a proper barrier LPN-F should have disinfected ately, and if the wheelchair did h the soiled area, it should dimmediately. RN-B also ould have been placed scissors and R118's night ed stockinet should have been and replaced with a clean one. material was obviously soiled it alaundry for cleaning. On Control Committee- Duties is policy dated 6/14, directed attee was responsible for programs for all facility ion control policies and immittee was also responsible in ity maintained a sanitary all personnel following in control procedures and incility's training program was to protective barrier equipment, intamination and disposal of exposed to blood/ bodily fluids. THOD OF CORRECTION: Sing or designee, could review by policies and procedures control practices during Responsible personnel could these policies and procedures.	21375				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 71 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00714	B. WING		10/2	6/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF MN 55313,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ige 71	21375				
	implemented, with Quality Assessmen ensure on-going co	could be developed and results shared with the facility's t & Assurance committee, to impliance. R CORRECTION: Twenty-					
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			12/29/15	
	maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements	e provider must establish and hensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease action (CDC), Division of the nation, as published in CDC's active Weekly Report (MMWR). Include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.					
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the ure employees received a skin test (TST) for 5 of 8 new		Corrected.			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF PRO	VIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
LAKE RIDGI	E CARE CENTER (OF BUFFALO	BOULEVAF MN 55313,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
Entre restricts Fin Reference and was well and an annual steel st	viewed. This had sidents who residents who residents who residents include: eview of personner	personnel records were the potential to affect all 42 ed in the facility. Pel files for a sample of new ed nursing assistant (NA)-B 5. Although an initial TST in 7/23/15, and read as luration on 7/25/15, a second eted. Phired on 8/26/15. Although een administered on 8/26/15, re with no induration on step had been completed. Politically an initial TST in the distriction on 9/10/15 and read as luration on 9/13/15, no second poleted on entrance of the was hired on 9/10/15. TST had been administered d as negative with no 5, no second step had been in the first step TST had not been in	21426			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 73 of 137 28WI11

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP		SURVEY LETED		
			A. BOILDING.			
		00714	B. WING	·····	10/2	6/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ige 73	21426			
	in Minnesota Health 7/13, directed testir with Mycobacterium either a two-step T3 release assay (IGR SUGGESTED MET The director of nurs develop and impler related to the requipercess. The qualicommittee could be ensure compliance	THOD FOR CORRECTION: sing (DON) or designee could ment policies and procedures red tuberculosis skin testing ty assessment and assurance erform random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21475	MN Rule 4658.1009 General Requirement	5 Subp. 1 Social Services: ents	21475			12/29/15
	home must have and department or progrelated social service nursing home must collaborate with out who is in need of accordance.	Il requirements. A nursing norganized social services aram to provide medically ces to each resident. A make referrals to or tside resources for a resident additional mental health, or financial services.				
	by: Based on observative review, the facility for related social service provided for 3 of 4 in the social service	ent is not met as evidenced ion, interview, and document ailed to ensure medically ces needs were identified and residents (R29, R28 and R56) services. This resulted in		Corrected.		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 74 of 137 28WI11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE: A. BUILDING: COMPL			SURVEY PLETED	
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAR MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21475	actual, psychosocial expressed fear, inal demonstrated signs concerns with her resident from the signs concerns with her resident for the sident had severed had demential with a sident for the sident had severed had demential with a sident for the sident had severed had demential with a sident for the sident had severed had demential with a sident for the sident had severed had demential with a sident for the sident had severed had demential with a sident for the sident had severed had demential with a sident for the sident f	al harm for R28, who bility to sleep, and so of distress regarding commate (R29). imum Data Set (MDS) dated the resident had severe and and had dementia with S dated 9/1/15, indicated the ecognitive impairment, and depression. The MDS depressed, had trouble or no energy, felt bad about buble concentrating. Seessment (CAA) dated the resident received Zoloft, and diagnosis of depression. The defended she was to receive one to one visits to ion of feelings and to, "Explore or the resident's distress (e.g., thosocial stressors, treatable etc); Implement a mood to compliment drug therapy: The care plan indicated R28 response from others related to the approach was for staff to issues with the team members aluate the need for ral and evaluation. The serviewed from 7/09/15, to the following incidents related	21475			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 75 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0714

MAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

A. BUILDING:

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

(X3) DATE SURVEY COMPLETED

10/26/2015

NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LAKE RI	DGE CARE CENTER OF BUFFALO	BOULEVAR , MN 55313	D				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
21475	Continued From page 75	21475					
	On 7/9/15, "Res. [resident] has been crying today. Res. is stating how when she was little her mom used to make her watch the baby and she didn't like it. Res. has also been say that her roommate asks so many questions and needs things and she is getting tired."						
	On 7/15/15, a note documented by activities indicated "Resident is having a hard time with her rooming situation. She says she is not getting much sleep because roommate is up a lot at night talking, delusional as to where she is and accusing resident of things. Resident is crying a lot and is in hopes of changing rooms. Writer consoled resident and said she would see what she could do about the situation."						
	On 8/24/15, resident and roommate had a dispute. R28 stated her roommate yelled at her and she became upset, was crying, and stated she was done dealing with her roommate and wanted a new room.						
	On 8/25/15, a progress note from social services indicated, "Spoke with res regarding incident with roommate last night, res did remember arguing with her roommate. She didn't say she wanted a different room today, but just said that she didn't want to talk to her roommate about just anything, only the weather. Writer validated her feelings letting resident know she doesn't have to talk to roommate about anything she didn't want to."						
	On 9/1/15, "Resident refusing to go into bed as roommate blocking roommate from entering. Resident when in room, 'peeks' into roommates side of room to make sure she is okay."						
	On 9/5/15, resident talked with writer and stated,						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00714	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21475	"I'm loosing my min on me; up at 1 am. room, did leave a m worker], 1 on 1 with this time." On 9/10/15, resider well last night statin her up asking who so the court of the	id, my roommate is rubbing off Talks of wanting a different nessage for SW [social a resident, and was effective at a tresident, and was effective at a tresident of not sleeping as the lady in her room kept she is and where she is. It complaints of not sleeping as the lady in her room kept she is and where she is. It is note from social services as walking down the hall and and was upset because she and the tresident of the room social services and who stole her able to say. Res roommate at of the room and res said 'oh was screwing with him all sknow that was not nice to call writer asked who him was and the res said 'oh look here she is crew' and she shook her fist at directed ladies in opposite some time for residents to go so. Res kept stating that 'this is goes in there all the time and such a little bitch, I cant even	21475			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 77 of 137

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/	26/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21475	neck- I don't sleep Res. stated 'I really any sleep with her irelief. SS updated. On 10/6/15, social residents daughter concerns that resid who was after her a sleeping with all so just wanted to com [daughter] that no resident have men [daughter] stated and they turn out to does not have men [daughter] stated slabout it. She [daughter] stated slabout it. She [daughter] stated slabout it. She [daughter] with the suicide comme call from the MD [mon Thursday and Worker then spoke that and res has no plan at facility. No further today." On 10/07/15, "Res Res in hallway this about going to 'See what the weather is talking about how a kicked.' Res event into her room. Will A Lake Ridge Care form dated 10/8/15 to call R28's daugh	t? 'That cord for around my cause of that lady in my room.' wont do that but I never get in there.' 1 on 1 was given with	21475				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00714	B. WING		10/	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF RUFFALO 310 LAKI	DDRESS, CITY, S' E BOULEVARI O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21475	On 10/20/15, "Write assistant registered said she was going daughter to inform asked aides what he roommate didn't was said she didn't wan the claim that room Aides said roommate make such a commiseparated at this tirbed." On 10/22/15, social with resident and don 10/20/15. Resisted her roommate was going she felt safe and with the stated her roommate during times resident came to with the second of the same to with the second of the same to with the same to w	er informed by NAR (nursing d) that Res claims roommate to cut her throat. Res called daughter of situation. Writer appened. Aides said ant to go in room because Res ther there. Then Res made mate said she'd cut her throat. It wasn't even around Res to nent. Res and roommate me. Res on her way back to discussed comments she made stated that she did not feel her ng to slit her throat, res stated as not afraid of her roommate. It wasn't even around Res to nent. Res on her way back to discussed comments she made stated that she did not feel her ng to slit her throat, res stated as not afraid of her roommate. It way res twice if she felt safe with ng the conversation and both her hands at writer and said oh all service note indicated riter upset with roommate or visitors and that she needed on because her roommate de shuts the door on her. So upset writer asked if she felt and res stated, "No, I don't dent was up at the front door out of here." Writer told ning out. You don't want to go t replied, I don't care about the ghere another night; live with				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 79 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	•	
LAVE DI	DOE CADE CENTED	310 I AK	E BOULEVAF			
LAKE KI	DGE CARE CENTER	BUFFALO BUFFALO	O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 79	21475			
	was resistant at firs go to the Vineyard. social services and put a Wanderguard An Associated Clini dated 8/17/15, indicand did not have surecommendations was associated.	here, I'm leaving. Resident to but then writer got resident to Writer reported this info to nursing. At this time nursing on resident." c of Psychology visit note cated R28 had depression, sicidal ideation. The were to use validation ne appeared to have concerns				
	dated 9/10/15, indic get a bit weepy toda conflicts with her ro staff and apparently with at least a coup	s Of Minnesota physician visit cated, "The patient [R28] did ay while complaining about ommate. I spoke with various to the patient has had problems le of other roommates and I candidate for a private room."				
	to support a waiver There was no indicate recommendation re	garding R28 receiving a				
	During interview on nursing assistant (N started to have trou months ago, becau late afternoon and more confused, and night. NA-T stated early morning and F of bed crying stating roommate because uncomfortable." R2 "Doesn't like being	ollowed up on by the facility. 10/26/15, at 1:53 p.m. NA)-T stated R28 and R29 bles being roommates a few se R29 gets, "Crazy" in the night time. R29 becomes d is up hollering during the they have come to work in the R28 would be awake and out g she is fearful of her R29 was, "Making her R29 was, "Making her R29 had expressed she, in that room," and continued to the R21 would be remain in the room				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 80 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO 310 LAK	DDRESS, CITY, S E BOULEVAR O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21475	with R29. R28 had times a week of not because of R29, ar were reported to so stated she had spo didn't want the resid rather just wanted t pictures and music space of the room to R28's daughters had change rooms becawas," between R28 stated, "Nothing ever R29 rooming togeth. During interview 10 stated R28 and R29 [R29] is very forget minutes to the next room she is on and things and it upsets upset and will go or her family; she has never told me she is suicide checks. We charting to separate charting. It would be separated."	d ongoing episodes several is sleeping well at night of NA-T stated these concernsicial worker (SW)-A, but SW-Aken to R28's family and they dent to change rooms, but he facility to add some to try to enhance the physical for R28. NA-T stated one of odd recently visited from out of expressed desire for R28 to ause she could, "See how it and R29; however, NA-T er got done," about R28 and her. 1/26/15, at 4:08 p.m. NA-A and ful; she cant remember five they both dig into each others to both of them. "[R28] gets in a rant that she has no one in said she is better off dead but had a plan. She is not on any er are told there is not enough the nice if they could be				
	practical nurse (LPI R29] fight a lot. I ha and left messages almost ready to give nothing gets done we frustrated, they don and about what wo be compatible with	/26/15, at 4:13 p.m. licensed N)-A stated, "They [R28 and ave asked for a room change with the social worker. I'm e up; we keep charting and with it and the staff are very 't ask us about room changes ald work best, and who would who. I suggested for her om 126 when that was open				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 81 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2)6/201E
					10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	because I felt her a be a good fit and the tells me she wants that she wants to keep occur." LPN-A statit with each other in During interview 10 stated, "I have never my life." R28 states present at the time Kleenex. R28 states room, I want a differ gals that work here wiping her tears with began rubbing her am so tired of this, mind to end my life have to put up with roommate (R29), "I p.m., R28 was still During interview on worker (SW)-A state aware R28 and R2 stated she and the discussed moving the rooms, but felt it woelther one of them. hallucinates and ham an being in the roman around. SW-R29 was keeping Find asked R28 aboshe had never had	and the other roommate would be never moved her. [R28] to move [R28] says things ill herself." LPN-A then stated, are charted as often as they led R28 and R29 just, "Got into in the hall." 2/26/15, at 4:23 p.m. R28 are been treated like this ever in led to cry, and LPN-A (who was of interview) gave her a led, "I have asked for a different erent room, and I have told the entat!" R28 continued to cry the her Kleenex. R28 then head and stated, "Oh my god I have it in the back of my lam 86 years old, why do I this?" R28 stated her las nastier than nasty." At 4:33 crying. 2 10/26/15, at 4:36 p.m. social led everyone at the facility was 9 did not get along. SW-A director of nursing (DON) had the residents to separate buld not be a benefit to move SW-A stated R28 and made comments about a som when there hasn't been a A stated she was not aware if R28 up at night, and stated she but her suicide thoughts and a plan. SW-A stated she had		DEFICIENCY)		
	however, her daugl move. SW-A state	28 to a different room, hter in law did not want her to d the facility did not currently oms available, and the empty				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 82 of 137

Minnesota Department of Health

AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21475	rooms all have room they would rather wo before moving R28 filled out a waiver for will wait until the rest the room, and there the near future. SV by the Associated Cowere to be seeing Fhowever, the last til there currently was scheduled. SW-As the Psychology clin months, because the good about keeping residents here." During interview 10 family member (FM R28's concern with resident does compand aware the physprivate room for R2 to her about moving room. During interview 10 stated a lot of the see between [R28] and was not aware whe with the situation be SW made the determined assignments, am not sure why the them." DON stated comments from R2 made a comment assignment as sure whose sure who	mmates, and the facility felt rait for a private room to open. SW-A stated she had not or a private room because she sident was actually moved into emight be a couple opening in V-A stated R28 had been seen clinic of Psychology and they R28 on a monthly basis, me visit was 8/17/15, and not a follow up appointment stated she would need to call ic being it had been a few he Psychologist was, "Not very go her schedule with the roommate, and the colain to her about it. FM-A was ician had recommended a rec				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00714		B. WING		10/2	26/2015	
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO 310 LAK	DDRESS, CITY, S E BOULEVAR O, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21475	Continued From pa	ige 83	21475			
	identified diagnoses bipolar, anxiety, demental disorders di condition. R56's Initial Pre-Adresults based on in 9/9/15, by the Buffa SW-C, identified shintellectual disabiliti "Based on the infornursing home stay, the criteria for DD [needs to be referre evaluation. Please need for referral for made by Senior Lim 1 screening dated Wright County case R56 did not have a related condition (Diconsidered to have evidence that migh of DD/RC, and had or boarding care fathat served personadditional PASRR I 9/11/15, was maintain record. This screen registered nurse (Fagency identified or declared R56 did hevidence was presente presence of DD identified, no referral forms.)	ident Admission Record including diabetes mellitus, pression and other specified are to known physiological dission Screening (PAS) information submitted on allo Hospital social worker he had a diagnosis of mild dies. The screening noted, imation provided for this it appears this person meets developmental disability] and dies to the lead agency for further note final determination of the further evaluation will be askage Line ®." A PASRR level 19/10/15, completed by R56's in manager/ SW-D declared developmental disability or DD/RC), had never been DD/RC, had no presenting thave indicated the presence not been referred for nursing cility placement by an agency is with DD/RCs. However, an evel 1 screening dated ained as part of R56's medical ained as part of R56's medical ained as part of R56's medical ding was completed by th)-F, with no associated in the forms. This screening ave a DD/RC and presenting ent that may have indicated D/RC. Though conditions were all was made for completion of valuation. The facility did not of these conflicting				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 84 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 .0/2	
LAKE R	DGE CARE CENTER	OF RUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21475	screenings, to ensuappropriate support Her admission MDS cognition was intact assistance for most (ADLs), but require for eating. The MDS therapeutic diet and The CAA dated 9/1 assistance with all of for hypoglycemia. It is to participate. She maybe looking foster home. Husbar for her." The CAA reference the diabetes. The CAA well with good intaken R56's care plan darprovide her with a context of the total context of the total context of the total context of the facility and R56. Her physician order following: GlucaGen 1 milligrating injection; one dose blood glucose where sugar by mouth, statantus 100 units/milligration.	are R56 received the ts. S dated 9/17/15, identified her t and required extensive t activities of daily living d only supervision and set up S identified R56 was on a d received insulin medications 7/15 noted,"[R56] is needing ADLs following hospitalization Needs encouragement from Discharge plan is uncertain. at moving to a group home or and is having difficulty caring noted R56 was on a ated to her diagnosis of noted, "Resident tolerates diet are and good glucose levels." ted 10/22/15, directed staff to diabetic diet of mechanical soft lan directed R56 was to and set up for eating. The rther address R56's diet, to support R56 in a diabetes, direct interventions elation to her intellectual coordination of care between 's county case manager. Trs dated 10/23/15, directed the am (mg); intramuscular as needed for severe low in R56 was unable to take	21475			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 85 of 137

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NOMBER: A. BUILDING:	TED
00714 B. WING 10/26/2	/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
21475 Continued From page 85 for diabetes, with dosing adjusted on 10/23/15. Novolog 100 units/mL 6 units; subcutaneously injecting before breakfast, before lunch and before supper and holding if R56's blood glucose was less than 150, for diabetes, with dosing adjusted on 10/23/15. Novolog Flexpen 100 units/mL sliding scale (200-250 = 3 units, 251-300 = 5 units, 301-350 = 8 units, 351-400 = 10 units, -400 = 12 units); subcutaneously injecting before breakfast, before lunch and before supper, for diabetes, with dosing adjusted on 10/23/15. Accucheck (blood glucose monitoring) at 3:00 a.m., 7:00 a.m., 11:00 a.m., 4:00 p.m. and 7:00 p.m. daily, ordered on 10/23/15. Diabetic diet with mechanical soft textured food, with an order date of 10/23/15. "Very important for patient to be on a diabetic diet. All junk food should be removed from patient's room." The order start date for this directive was 10/14/15. Review of R56's Vitals Report from 9/10/15, through 10/26/15, identified her blood glucose levels were unstable, with extreme highs and extreme lows. Blood glucose readings under 50 mg/ deciliter (dL) and over 500 mg/dL included the following: 9/12/15 (45 mg/dL), 9/15/15 (44 mg/dL), 9/16/15 (572 mg/dL), 10/2/15 (586 mg/dL), 10/20/15 (584 mg/dL), 10/2/15 (586 mg/dL), 10/20/15 (584 mg/dL), 10/2/15 (586 mg/dL), 10/20/15 (584 mg/dL), and 10/23/15 (584 mg/dL), and 10/23/15 (584 mg/dL), and 10/23/15 (584 mg/dL), included the following evidence of education provided to R56 in relation to her	

Minnesota Department of Health

with her diet:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
00714		B. WING		10/2	6/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	10/2	.0/2013
		310 I AKE	BOULEVAR			
LAKE RI	DGE CARE CENTER	OF BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 86	21475			
214/5	On 9/15/15, at 8:25 noncompliant with [with resident this exbutter] sandwich, 2 resident all of which snack." On 9/16/15, at 4:21 noted, "[R56] would regarding her meal: On 9/17/15, at 9:13 (CDM)-A noted, "Sabreakfast and discumsure of what she to order on a diaber carbs [four to five cand to go for health the chips and pop. gave her some read also gave her a mir order and still be in On 9/17/15, at 9:15 nutritional assessmincluded, "Resident She is independent member has set he 76-100%.	p.m. LPN-D noted, " diabetic] diet; spouse in to visit vening; brought in PB [peanut [two] bags chips and soda for a she ate for HS [bedtime] p.m. registered nurse (RN)-C I like to talk with the dietician s. Message left with manager." a.m. certified dietary manager at down with resident at ussed her diet. Resident was was supposed to eat and how tic diet. We talked about 4-5 arbohydrate choices] a meal y carbs like fruits vs [verses] We spoke about sugars and I ding materials on diabetes. I hi meal cheat sheet to help her her carb count." a.m. CDM-A noted her initial ent for R56. The assessment is currently on a Diabetic diet. with eating once a staff or up. Her intakes are dependent with her ordering seled as to how many carbs to to watch her sugar intake. To try to have a half sandwich to has been having a hard time or snack Will provide diet per veights and intakes for	214/5			

Minnesota Department of Health

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 87	21475			
214/5	On 9/23/15, at 11:1 is not compliant wit resident does usua items, resident eats a large amount of s room." On 10/13/15, at 10: "Resident has beer [and] yesterday mo On 10/15/15, at 5:2 left facility again to to KFC and will r/t [i On 10/21/15, at 2:0 "Resident has beer appropriate meal se On 10/22/15 at 1:20 "Resident's husban lunchtime." On 10/22/15, at 11: "Resident noncomp Has variety high ca reviewed diabetic contike these." On 10/23/15, at 12:0 "Appetite is good; con high carb snack [primary medical dodiet." On 10/24/15, at 8:4 to educate on her dodiet." On 10/24/15, at 8:4 to educate on her dodiet." On 10/24/15, at 8:4 to educate on her dodiet."	2 a.m. LPN-F noted, "Resident n dietary needs. Although ly choose to eat sugar free a lot of carbs Resident has ugar free candies in her 42 a.m. LPN-F noted, snacking on chips today et	214/5			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 88 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			71. Boilesina.			
	00714 B. WING 10/20		6/2015			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21475	extremely erratic are then way low. She is non-compliant with longstanding issue. She stated facility is about her diet and should or should not had to honor her rightem take snacks on R56's husband was her. She added, fact all of the time, with During interview on practitioner (NP)-B R56's diet non-com R56 had the capact decision about her that is why we are the group home." NP-E medical doctor had the Wright County of SW-D, who was as discussed dischargishe was scheduled the following week, allow R56 to return services. However, tried that, she turns leave and go home did not allow in-hon provide the support "Really the only wa would be to commit husband, also did ridecisions on her be of whether SW-D withis time. NP-B statemedical doctor were	and that they wient way high, said that R56 was her diet and this had been a from prior to her admission. Staff talked with her frequently educated her on what she of have been eating, but they got when she declined to let out of her room. RN-H stated is bringing lots of snacks in for cility staff tried to educate him	21475			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 89 of 137

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER (OF BUFFALO	BOULEVAR	D		
		BUFFALC	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 89	21475			
	to remove the snac he was not surprise	ce if she would not allow them ks from her room. He stated to learn snacks of chips and erved in her resident room k.				
	1:00 p.m. R56 denicher about how to monfines of her dietalk to her about who she stated they tolebread and fruit. R56 allowed the staff to if they wanted to. Slif they could remove stated she knew ho compliance with he ate what she wante to eat with her husb potato chip bags we R56's resident room opened, with approxemaining. R56 affin brought snacks into	•				
	sated she had note a PASRR level 2 wh screening before sh admission, "but the across as not being Senior LinkAge Line facility when a level then a county worke facility to complete reported she did no responsibility to folk come out. When as	10/26/15, at 9:06 a.m. SW-A d R56 as potentially requiring nen she did her pre-admission ne was accepted as a new n she ended up coming a level 2." SW-A stated e ® typically contacted the 2 evaluation was required, er typically came out to the the level 2 screening. SW-A t know if it was the facility's ow-up if the county did not sked whether R56 had a pmental disability, SW-A				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 90 of 137

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. Bollbind.			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475	stated she did not a medical record to shospital told her R5 very involved and the potential placement stated, "If you talk was eems like there was SW-A confirmed shaped to make the compliance with he consultation with reeducation materials R56's comprehensitime of interview, Sof chips from anoth stated it was 'contrawas not supposed the stated that it was pastaff to check his remove anything for there had been any arrangement to be that the other reside which limited his abcomplement such a protocoordinated with identify any social solution. SW-D stated in services from an inprovider who tried of develop a calendar eating. SW-D state proved successful a have the capacity to should be serviced successful a have the capacity to should be successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a have the capacity to state of the service successful a service s	tee any diagnoses in her support this. She stated the 6's county case manager was nere was discussion of at a group home. SW-A with her and are around her it buld be a DD diagnosis." The was not involved in assisting	21475			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 91 of 137

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00714	B. WING	B. WING		6/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
	310 I AKE	BOULEVAF	,		
LAKE RIDGE CARE CENTER (OF RUFFALO), MN 55313			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
"definitely" required and the county was pursuance of legal of about R56's diagnosis ome indication of a did not see anything actual diagnosis of thowever, as the commentioned some psecompleted for R56 aprior. Upon further intesting identified an 63 and included a nintellectual disability Report signed 3/25/psychological testing at Nystrom & Associpsychologist (LP)-A a Wechsler Adult Im Edition (WAIS-IV), for resulting diagnosis of disability. During interview on stated R56 had a losugars. She stated, hypoglycemic event who arrived at the sand had indicated a similar calls when R stated facility staff hand her husband reshe added, "as of person and she can When asked whether understand the risks diet, RN-H stated, "	to work with her on r diet. She reported R56 more one-on-one attention currently considering the guardianship. When asked ses, SW-D stated there was a learning disability, but she g in her record identifying an developmental disability. Inversation progressed, SW-D sychological testing that was approximately six months nquiry, SW-D stated the intelligence quotient (IQ) of	21475			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 92 of 137 28WI11

Minnesota Department of Health

AND DUAN OF CODDECTION DENTIFICATION AND DED	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
00714	B. WING	- 10/26/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDR	RESS, CITY, STATE, ZIP CODE	
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE B BUFFALO, I	BOULEVARD	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLA PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETE DATE CIENCY)
bipolar disease I think there is some cognitive impairments with her Maybe a group home or foster home would be a better option, but guardianship is not in place yet." RN-H was asked what adaptations, if any, had been made to the verbal education and education materials provided to R56, to optimize her understanding. She replied she was unsure whether any adaptations had been made. However, she added, "Mainly it is more the staff reminding her When it's snack time she does have a sandwich and dietary is involved at meal times. When dietary staff take her order they can make recommendations on healthier options." During interview on 10/26/15, at 4:56 p.m. the DON stated the facility's social service department was responsible for overseeing the PASRR process. She stated she did not believe there was anyone in the facility who required a PASRR level 2. She stated she was not aware R56 had a diagnosis of intellectual disability. She stated, "If I had known yes, we would try to work with her where she is at." The DON reported she was unsure whether facility staff had made any adaptations or provided any kind of specialized support to R56 with regards to her diet. She added, "Her diabetes is so significant, she has some needs that I think are a little different we do what we can to identify them I would expect the social worker to be coordinating that [any specialized supports] and then nursing interjected into that." A facility policy addressing the responsibilities of social services was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review	21475	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING 10		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
21475 21530	and/or revise facility related to medically Responsible persor these policies and perforts could be masocial service need in the deficiency, with maintained. Other for social service necould be developed results shared with Assessment & Asson-going compliance. TIME PERIOD FOR (14) days.	y policies and procedures related social services. In policies and procedures related social services. In policies and procedures. Appropriate de toward supporting the sof the individual(s) identified the supporting documentation residents could be evaluated peeds. An auditing system I and implemented, with the facility's Quality urance committee, to ensure	21475			12/29/15
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finand This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or se pharmacist. For pu upon" means the ac	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is not entire interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports in by the time of the next coner, if indicated by the proses of this part, "acted acceptance or rejection of the nig or initialing by the director				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0714

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:
B. WING
10/26/2015

LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE					
21530	Continued From page 94	21530							
	of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.								
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist recommendations to establish pain medication parameters for use were acted upon for 1 of 5 residents (R5) reviewed for unnecessary medication use.		Corrected.						
	Findings include:								
	R5's quarterly Minimum Data Set (MDS) dated 9/15/15, identified R5 had intact cognition, no pain, and required extensive assistance with his activities of daily livings (ADLs). The MDS identified R5 had diagnoses including chronic osteomyelitis [an infection of the bone or bone marrow] and a non-pressure related foot ulcer.								
	R5's signed Physician Order Report dated								

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	·	
LAKE RI	DGE CARE CENTER	OF BUFFALO	KE BOULEVAF LO, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21530	10/6/15, identified nincluding the following	nedication orders for pain ing: nedication used to treat pain ablet; 650 mg [milligrams] n Every 4 Hours - PRN [ast-like pain reliever] - Scheduling; Every 6 Hours - PRN. an orders did not provide or exters or direction for when administer the resus the Tramadol to help armacy Drug Regimen ne following, "Potential by [siden," to be acted upon by facilities check if there are ag prn Acetaminophen vs " MR [medication regimen if not addressed." 1/3/15, MMR #5. Does not	e con ald			
		would complain of, however				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 96 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	E BOULEVAR D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530			21530			
	staff were treating I reviewed R5's EMA administration reco	hed parameters would ensure R5's pain consistently. LPN-A AR (electronic medical and stated there were no eters for R5's as needed pain				
	During interview on 10/26/15, at 9:54 a.m. registered nurse (RN)-A stated the nursing staff reviews the pharmacists recommendations after each visit and updates the physician with the pharmacy recommendations. RN-A reviewed R5's medical record and stated the recommendation by the pharmacist to establish parameters for R5's as needed pain medications was not addressed, and stated the recommendations should have been followed up on, "That's an issue."					
	During interview on 10/26/15, at 11:14 a.m. the consulting pharmacist (CP) stated he allows facilities a certain time period for staff to address his recommendations, however, the facility should have addressed the recommendations made on 8/3/15, 9/2/15, and 10/1/15, and stated, "It should be done."					
		medication regimen review and requested, but none was				
	The medical director and/or their designor facility policies and medication regiment resulting recomment personnel could be and procedures. T	THOD OF CORRECTION: or, consulting pharmacist ees, could review and/or revise procedures related to reviews and response to ndations. Responsible re-educated on these policies he medication regimen of the ted in the deficiency could be				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 97 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR			
			, MN 55313		ON!	0.5
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 97	21530			
	reviewed with recommendations discussed and acted upon and supporting documentation maintained. Consulting pharmacy recommendations for other residents could be evaluated for appropriate response. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.					
	TIME PERIOD FOR CORRECTION: Thirty (30) days.					
21545	MN Rule 4658.132	0 A.B.C Medication Errors	21545			12/29/15
	A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or					

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING _ 00714 10/26/2015

NAME OF	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE RI	DGE CARE CENTER OF BUFFALO		BOULEVAF , MN 55313					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCI (EACH DEFICIENCY MUST BE PRECEDED B' REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
21545	Continued From page 98 toxicity. All medications are administered prescribed. An incident report or medication report must be filed for any medication resident reactions must be reported to physician or the physician's designed a resident or the resident's legal guardian designated representative and an explainment be made in the resident's clinical C. All medications are administered prescribed. An incident report or medication occurs. Any significant medication error resident reactions must be reported to physician or the physician's designed a resident or the resident's legal guardian designated representative and an explainment of the made in the resident's clinical must be made in the resident's clinical	ication cation error a errors or the and the an or canation record. d as cation error error that ors or the and the	21545					
	This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 1 residents (R45) who had a medication error in which they received the incorrect dosage of insulin that caused low blood sugars with physical symptoms. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated the resident was cognitively intact, had diagnoses of diabetes mellitus, and received daily insulin injections. Review of the Buffalo Clinic Telephone order report dated 4/8/15, indicated the facility was instructed by the clinic to notify the physician if			Corrected.				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00714		B. WING		10/	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO	310 LAKE	DRESS, CITY, S BOULEVAR D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21545	R45 had blood sug- milligram/deciliters range 80-120 mg/d Review of the Allina which included phy- indicated R45 was acting insulin] as of units in the morning now."	ars below 80 (mg/dl), normal blod. A Health Clinic Buffasician orders dated to, "Continue Lantus the last dosage who, are Center signed Plodated 4/20/15, indicated 4/20/15, indicated to go, "Back on lant ver, there was no in iving Lantus at bedfast, and the morning to the receive the safe to go, and the morning; douing the morning the	lo note 4/16/15, s [long ich was 37 sage for hysician cated morning. ght time 4/20/15, us 37 units dication ime prior, antus 37 added 37 crently significant from the n History units once Lantus at ong with ubling R45 /20/15, to	21545			
	Report identified or						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
LAKE R	IDGE CARE CENTER	OF BUFFALO	KE BOULEVAR LO, MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21545	blood glucose was deciliter). Review of indicate the physicist blood sugar, nor did residents insulin hat R45's Resident Profindicated the resident checked when the reand was only 51 mg record did not indicated the low blood sugar the residents insulin 4/20/15. R45's Resident Profindicated was 51 mg/dl. Rev not indicate the physhlood sugar, nor did residents insulin hat R45's Resident Profits 33 a.m. indicated sugar) this morning She had a BS of 38 s:44 a.m. and updated A Buffalo Clinic Telepatient should actually bed time, as the factorders did not mater A Buffalo Clinic Telepatient should actually bed time, as the factorders did not mater A Buffalo Clinic Telepatient should actually bed time, as the factorders did not mater.	only 52 mg/dl (milligrams per of the medical record did not an was notified of the low did the facility identify the did been doubled on 4/20/15. Igress Note dated 4/25/15, ents blood glucose was resident was eating breakfast g/dl. Review of the medical ate the physician was notified gar, nor did the facility identify in had been doubled on a did the facility identify in had been doubled on the facility identify in had been doubled on a did the facility identify the did been doubled on 4/20/15. Igress Note dated 4/27/15, at the residents blood glucose iew of the medical record did a did the facility identify the did been doubled on 4/20/15. Igress Note dated 4/27/15, at the facility identify the did been doubled on 4/20/15. Igress Note dated 4/27/15, at the facility identify the did been doubled on 4/20/15. Igress Note dated 4/27/15, at the facility identify and shaky. In the physician was called a did on R45's low blood sugar ard a shaky. In the physician was called a did on R45's low BS in a side of the low blood sugar ard in the telephone mindicated at 4:46 p.m. Lakefail be on 37 units of Lantus a collity just noticed the insulin	d at			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKI	DDRESS, CITY, S E BOULEVAR D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICIENCY)	JLD BE	(X5) COMPLETE DATE
21545	p.m., "Discussed w 4/20/15, visit had w units at bedtime, wh daily MORNING DO patient has been redaily since the last sugars." MD-B ord daily in the morning R45's Resident Pro 5:37 p.m. indicated Lantus 37 units BID miscommunication appointment. Spok dose has been d/c'c continue the 37 unit T.O. (telephone ord During interview 10 nursing (DON) state insulin medication error renurses should have they noted the orde on 4/20/15, since the that dose before, are current insulin she stated that she had residents orders to problem. DON state training related to the because she was not a state of the sta	ith [staff] by phone. As of ritten to return to Lantus 37 nen it should have been once DSE> Clarified with [staff] ceiving lantus 37 units twice visit with recent low blood ered Lantus 37 units once as prior to hospital stay. gress Note dated 4/27/15, at "Resident had been receiving 0 (twice daily) since 4/20, written upon return from the with [MD-B] and the HS d [discontinued] and will the transport of the standard previous				
	in morning only, and the order to double	oreviously on Lantus 37 units d had a history of low BS after the residents insulin dose on failed to clarify with the				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 102 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	physician the additi at HS, nor did the fawhen R45 had low 4/25/15, and 4/26/1 the physician until 4 insulin dose was do a low blood sugar osymptoms. Also, the looked at other resi prevent other potents SUGGESTED MET. The director of nursiand/or revise facility related to medication significant medication transcription process could be re-educate procedures. The mindividual(s) identification reviewed for accurate supporting docume investigation could root cause of this significant regiment evaluated for approand administration. developed and implication regiment with the facility's Quantum Assurance committed compliance.	onal order of Lantus 37 units acility contact the physician blood sugars on 4/22/15, 5. The facility did not contact 4/27/15, 7 days after R45's publed, when the resident had if 38 and experienced ere was no indication they dents, and educated staff to intial medicaiton errors. THOD OF CORRECTION: sing or designee, could review y policies and procedures on administration, preventing on errors and/or medication isses. Responsible personnel ed on these policies and nedication regimen for the ed in the deficiency could be acy and appropriateness, with intation maintained. An be completed to determine the ignificant medication error, on implemented to prevent occurring in the future. The ins of other residents could be periate transcription processes. An auditing system could be defined to ensure on-going. R CORRECTION: Fourteen	21545			
21665	MN Rule 4658.1400	9 Physical Environment	21665			12/29/15

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER DGE CARE CENTER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAR D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	A nursing home mu functional, comforta environment, allowi	ge 103 Just provide a safe, clean, able, and homelike physical and the resident to use so to the extent possible.	21665			
	by: Based on observati review, the facility for assessed and inter 1 of 1 residents (R7 himself while attem between his legs ard degree burns to his resulted in immedia remained at risk of failed to assess safe	ent is not met as evidenced on, interview, and document ailed to ensure safety was ventions were implemented for (3) who spilled hot coffee on pting to carry the coffee and obtained nine second lower left extremity. This ate jeopardy for R73, who serious injury when the facility ety with hot beverages and tions to prevent similar		Corrected.		
	4:50 p.m. when R73 degree burns (blister his lower left ankle coffee, and the faci assessment and imprevent reoccurrent the facility administ (DON) were notified (IJ) for R73. The IJ 8:24 a.m. but nonce isolated scope and	pardy began on 10/10/15, at 3 obtained nine second ering with partial thickness) to and foot from the spilled hot lity failed to complete an plement interventions to ce. On 10/21/15, at 6:06 p.m. rator and director of nursing d of the immediate jeopardy was removed at 10/23/15, at empliance remained at an severity level, which indicated not immediate jeopardy.				
	Findings include:					
	10/1/15, identified t	nimum Data Set (MDS) dated he resident had no cognitive d extensive assistance for				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		310 I AKF	BOULEVAF			
LAKE KI	DGE CARE CENTER	BUFFALC BUFFALC	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	nge 104	21665			
	bed mobility, transfers, locomotion on the unit, dressing, and toilet use. R73 required supervision with eating and had bilateral, functional limitations in range of motion, to both upper and lower extremities.					
	10/1/15, indicated I weakness from Frie which caused prog system and manife spasticity in lower liabsent lower limb r numerous falls at hadmission to the far required assistance	ssessment (CAA) dated R73 was at risk for falls due to edrich's Ataxia (a disease ressive damage to the nervous sted as poor coordination, imbs, muscle weakness, and eflexes), with a history of ome, and one fall since cility. The CAA indicated R73 with transfers, however, from staff to wait for help.				
	at 4:50 p.m. indicated resident's family methis wheelchair in the the vending maching dining area (hillside R73 was holding colost strength, or appfell to the floor out of was asked what he the fall, R73 stated out of the vending R73 was alert and had recently receive review indicated enthe fall were hot cocondition or diagnothe fall. The report to carry hot item in help." The root cau "Resident did not he	tigation Report dated 10/10/15, red another (unidentified) ember witnessed R73 fall from the facility's lower level, between the sand the rehabilitation eroom). The report indicated offee just prior to the fall, and peared to become weak, and to the wheelchair. When R73 ewas trying to do just before the had gotten a cup of coffee machine. The report indicated orientated, wearing shoes, and ed narcotic medication. The extronmental factors related to ffee and R73's physical ses as contributing factors to indicated, "Resident is unable [an] unsafe cup. Ask staff for use of the fall identified, ave the strength to hold [an] e cup." The Fall Scene				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 105 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR			
		BUFFALC), MN 55313			I
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 105	21665			
	and staff were educe R73 to be assisted the vending machinassessment of the ability of R73 to prevent further injure. An Event Details rep.m. indicated, "Respastic as a reactio foot- it is part of his him stiffen to come to the floor. Res. [Facility ad-lib [at will decisions based on spend leisure time.	residents wheelchair related to safely carry the hot coffee to ry. port dated 10/10/15, at 5:55 s. [R73] states his body went n to the hot coffee pain on his disease process that made out of his wheelchair and fall R73] is able to get around the l and make his own his judgement for how to Care plan was followed as nent continues to heal the burn				
	documented at 1:20 a skin injury on 10/1 left foot r/t [related to identified multiple be his left ankle and the moderate serous doubte injury site. Chaindicated blisters, ligurer superficial burns (in epidermis). R73's awas identified as, "Februard," and poor upper a possible contributed the skin injury dimensional management.	ers (cm) by (x) 2 cm, oval m, oval cm, circular				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 106 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
	00714	B. WING		10/:	26/2015	
NAME OF PROVIDER OR SUI	PLIER STREET	ADDRESS, CITY, S	STATE, ZIP CODE			
LAKE RIDGE CARE CE	NTER OF BUFFALO	KE BOULEVAF LO, MN 55313				
PREFIX (EACH DEF	RY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
Site 6- 6 cm site 7- 2 cm site 8- 3 cm site 9- 3 cm site	om page 106 (2 cm, no shape noted (3 cm, no shape noted (4 progress notes were reviewed fro ough 10/21/15, and indicated the (5:14 p.m. licensed practical nurse ated staff were alerted R73 had his wheelchair. R73 was found lyin e of his body and partially on his ary was obtained from the fall, en R73's wet clothes were removed dness was also noted to both of from the coffee spill. (at 4:01 p.m. LPN-C indicated a er had been obtained for Keflex (a dication) 500 milligrams (mg), twice is left foot burn. (at 1:50 a.m. LPN-D indicated the top of R73's left foot were intact if it. The blisters to the lateral, media sides were noted as opened. (at 1:24 p.m. registered nurse ted the dressing to R73's left foot anged and, "Blisters on top of foot ankle region, and outer ankle region listers have popped at this point. swollen, red, and covered with the blisters. Inner ankle blister is stippint. Patient denies pain to this progress notes had no assessment of the prog	g d, n,				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 107 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER		<u>l</u>	STATE ZID CODE	10/2	0/2013
NAIVIE OF I	PROVIDER OR SUPPLIER		BOULEVAR	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	machine, there was educated on asking there evidence staff ensuring R73 was recoffee to prevent furthere to prevent furthere to prevent furthere to prevent furthere to being wheelchair becontrol of body move the care plan noted Lt. [left] foot burn from the care plan goal without further comincluding the following the physician, Wou to be followed as neskin issues, lotion a changes in skin we and as needed, a period to be used in his wire to be done with tissue tolerance test facility policy to more reassessments of splan also identified to generalized weal included assessing needed, monitoring mobility as needed, removing the hoyer therapy as ordered plan did not address beverages, transpohow to minimize his that which occurred	a no indication R73 was a for staff assistance, nor was a for staff assistance, nor was a for staff assistance, nor was a for the burns. ed 10/16/15, identified a an skin integrity related to his bund, ataxia (loss of full rements) and medication use. d., "At risk for skin tears, etc om hot coffee spill 10/15." was for the burn to heal plications, with interventions ang: Treatments as ordered by and Care Standing Orders were edded and as appropriate for an electric section cushion was ressure reduction cushion was neelchair, a pressure reduction used on his bed, skin checks the bathing and as needed, and ting was to be done per the electric for skin risk, with the skin risk as needed. The care R73 as at risk for falls related an ess, and fall interventions his risk quarterly and as for safety and assisting with preventative measures of sheet after use, and physical and as needed. The care as R73's safety with hot retation of hot beverages, or a risk for burns/injury similar to	21665			
		g assistant (NA) care sneet he NAs use to know specific,				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 108 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	1 10/2	.0/2010
I AKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR			
	I	BUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	individualized residinformation regarding safety interventions injury, similar to that There was no indicto ensure R73 was obtaining coffee ou utilizing a safe cup. During interview on director of nursing R73 had gotten a comachine and spilled from his wheelchair coffee. During observation 9:21 a.m. R73 was was wrapped in gamultiple burns on h R73 stated he had vending machine downwas propelling his was propelling his was grasped some and his coffee spilled between his leg, and on his left foot. R73 had severe pain, he better. During this observed getting a belongings nearby Mt. Dew pop can in held the pop can in held the pop can in he took sips of his properties.	ent care needs), lacked any ng R73's burn, or direction of a to minimize the risk for burns/ at which occurred on 10/10/15. ation staff had been educated provided assistance when t of the vending machine and to prevent further burns. 10/20/15, at 9:44 a.m. (DON) stated on 10/10/15, offee from the facility vending d coffee, which led to a fall r as a reaction to the spilled and interview on 10/21/15, at lying in his bed. His left foot uze. R73 stated he had is left foot from spilling coffee. purchased coffee from the ownstairs in the facility and wheelchair and his wheels ewhat suddenly on the floor, ed which he was carrying and the coffee spilt into his boot 3 stated when it happened he owever, the pain has gotten observation, R73 was needle nosed pliers from his and used it to lift the tab of his order to open the can. R73 side a can coozie, and when pop he lifted the beverage up aised his neck to bring his	21665			
		note, "When writer asked, vill not be using the coffee				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 109 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DOILDING.			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	again.'Business a walk outside for f to help increase his progress notes sind 10/10/15, to indicat into place to ensure burns from the faci. During a follow up in p.m. R73 stated he downstairs prior to at the flavor selectic coffee vending machine. determining what k wanted, the (unider employee told him coffee out of the cowould not get burneasked an unidentifit they could help him vending machine a were not allowed to When asked why h coffee purchase, but with retrieving and he stated he had not arrangement. R73 putting his own mogetting his own coff machine. During the observed seated in room. His wheelch there were no adaptin holding a bevera observed self proper.	lone. 'I'm not going to do that Office Manager took [R73] for resh air and sun light in effort a mood." There were no other be the coffee burn occurred on e any interventions were put a R73 did not obtain further lity coffee vending machine. Interview on 10/21/15, at 3:21 had just recently gone this interview and was looking ons offered from the facility chine. R73 stated he wanted lavored coffees out of the However, he stated as he was ind of flavored coffee he ntified) business office he was not allowed to get offee machine anymore so he and again. R73 stated he then and they said no because they of handle resident money. The could not have made the cut had the staff simply assist transporting the coffee for him, but thought of trying that stated he was capable of they into the machine and fee out of the vending his interview R73 was his wheelchair in his resident wair had no arm rests, and obtations to the wheelchair to aid ge or any other item. R73 was alling his wheelchair with his were on the footrests, and his	21665			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 110 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF			SURVEY LETED	
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF , MN 55313	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	During interview on aide (DA)-B stated residents had been been told R73 need needed any monito interventions in place out of the vending redining room. During interview on (C)-B stated she had coffee vending made been told there were not be using the coshe aware R73 had coffee on 10/10/15. During interview on stated she referred direction on what in interventions were resident, and stated updated daily by the changes in care. Not told the NAs of any residents. NA-B states aware of any specified she was aware of any specified to drink supervision and/or from the vending made of the provided any estated she was aware of the provided any estated provided any estated provided any estated provided any estated she made and staff provided any estated she made and staff provided any estated she was aware of the provided any estated she made and staff provided any estated she was aware of the provided any estated she was aware of the provided any estated she made and the provided any estated she was aware of the provided she was aware	10/21/15, at 3:21 p.m. dietary she was not aware any burned by coffee, and had not led to be provided assistance, ring, or required any special ce related to obtaining coffee machine located outside the 10/21/15, at 3:21 p.m. cook at seen R73 using the facility chine in the past. C-B had not e any residents who should ffee vending machine, nor was a experienced burns from the 10/21/15, at 3:28 p.m. NA-B to the NA care sheet for dividualized cares and needed for each specific at the care sheets were exclinical coordinators with any la-B stated the nurses also significant changes with atted she was not aware of any received coffee burns, nor was pecial interventions in place for king hot beverages or requiring assistance to obtain coffee	21665			

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 111	21665			
	During interview on stated she was awa coffee from the ver burnt himself. NAhim with coffee or histated she could not she was in rooms that and stated, "He [R7] NA-D stated there in NA care sheets related to R73's burn histated R73's burn histated to R73's corand the event report of the facility invested to R73's corand the event report of the facility invested to R73 about told her he was, "Nimachine again." The DON stated R73 about told her he was, "Nimachine again." To prevent further in was to speak to him vending machine a care plan was updathappened as a resinterventions had be R73 from burning him than the discussion telling him not to us to get coffee. The aware R73 was downstain was downstain was downstain was downstain. R73 was downstain.	a 10/21/15, at 3:41 p.m. NA-D are R73 had purchased a ading machine downstairs and D stated staff were to watch not liquids, however, she of control where he went when aking care of other residents, [73] can do what he wants." was nothing specific on R73's ated to coffee or hot liquids. 10/21/15, at 4:07 p.m. DON nappened on a weekend, and he information, reports, ventions, and investigation free burn had been provided, and the information tigation and the interventions. [73's physician and family were as, and orders were obtained burns. The DON stated she to the burn, and the resident ever going to touch that coffee the DON stated the intervention highly from coffee burns for R73 in about not using the coffee gain. The DON stated R73's ated to address the fall that cult of the burn, but no een put into place to prevent himself with coffee again, other a she had with the resident se the vending machine again DON stated she was not winstairs earlier this day e another coffee from the She stated she was aware is earlier with the business DM) and had been emotional				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 112 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0714

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

310 LAKE BOULEVARD

LAKE RIDGE CARE CENTER OF BUFFALO STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD BUFFALO, MN 55313							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE			
21665	about his placement at the facility, but was not aware R73 attempted to get coffee from the vending machine. The DON stated R73 was safe to "go out ad lib" in the facility, and the assessment of R73's safety after the burn was "just what I have documented here [on the event report] as a result," as well as the information she added earlier today to the nursing progress notes. During a follow up interview on 10/21/15, at 5:18 p.m. R73 stated he typically ate his lunch and supper meals in the main dining room. R73 stated he did not need to use any modified utensils or adaptive equipment for eating. R73 also stated he, "Stripped it [wheelchair] all down" himself, because he did not like having arm rests on the chair as it made it easier to propel the wheelchair with his arms/ hands. R73 stated his wheelchair needed to stay like it was so he was able to move himself around the facility. The facility's Wound Prevention and Treatment	21665	DELICIENCI)				
	policy dated 6/14, directed individualized, preventative, interventions be developed based on the skin and risk assessments of each resident. The facility's Injury Documentation policy dated 6/14, directed documentation of injuries include an evaluation of contributing factors for the skin injury, a root cause of injury, and interventions in place. The care plan for skin integrity was to be reviewed and revised based on the resident's treatment and needs. The immediate jeopardy that began on 10/21/15, at 6:06 p.m., was removed on 10/23/15, at 8:24 a.m. when the facility completed the following interventions:						

Minnesota Department of Health STATE FORM

interventions:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	BOULEVAR	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21665	- The coffee vending the facility on 10/22 - R73 agreed to use hot liquids, and the updated to ensure sintervention If R73 would like thas agreed to ask stransporting it between trained to ensure safety equipment with the necessary adapts afety. On 10/23/15, from care staff, including and explained their was provided a covoliquids, and would be hot liquids he wisher room area. SUGGESTED MET The director of nursiand/or revise facility related to safety ha Responsible persor	g machine was removed from /15. e a covered cup when drinking residents care plan was staff was aware of the safety o transport hot beverages he staff for assistance vs een his legs. e building would continue to be y and nursing staff who had ure resident needing adaptive/sere assessed and provided of the equipment to ensure 7:45 a.m. to 8:08 a.m. direct dietary staff were interviewed knowledge of ensuring R73 ered cup when drinking hot be assisted to transport any ed to take out of the dining THOD OF CORRECTION: Sing or designee, could review y policies and procedures zards/ hot beverages. The procedure of the dining could be re-educated on	21665			
	The director of nurs and/or revise facility related to safety ha Responsible persor these policies and p identified in the defi for safety risks and could be implement documentation mai	sing or designee, could review policies and procedures zards/ hot beverages. In a could be re-educated on procedures. The individual(s) ciency could be re-assessed appropriate interventions				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 114 of 137

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00714	B. WING		10/2	26/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF D, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21665	Continued From pa	age 114	21665				
	results shared with Assessment & Ass on-going compliand	d and implemented, with the facility's Quality urance committee, to ensure ce. R CORRECTION: Fourteen					
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			12/29/15	
	residents shall, at a are legal rights for stay at the facility of treatment and main that these are desormitten statement of responsibilities set case of patients and as defined in section statement shall also person 16 years old provided in section shall list the names individuals and organdoracy and legal residential program accommodations sommunication impose a language of facility policies, insplication in the written statement to patients, resident chosen representation the administrator person, consistent	ation about rights. Patients and admission, be told that there their protection during their or throughout their course of attenance in the community and cribed in an accompanying of the applicable rights and forth in this section. In the mitted to residential programs on 253C.01, the written of describe the right of a dor older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide I services for patients in as. Reasonable hall be made for those with pairments and those who other than English. Current procedure the property of the and further explanation of ent of rights shall be available atts, their guardians or their tives upon reasonable request or or other designated staff with chapter 13, the Data section 626.557, relating to					

Minnesota Department of Health

PRINTED: 12/10/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00714 10/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21800 Continued From page 115 21800 vulnerable adults. This MN Requirement is not met as evidenced Based on interview and document review, the Corrected. facility failed to ensure 1 of 3 residents (R98) were provided the required notice of Medicare non-coverage upon termination of the covered services. Findings include: A facility Admission/Leave/Discharge Tracking Report dated 4/15/15, to 5/25/15, identified R98 was admitted with a payment source of, "Medicare Part A." and remained in the facility for 32 days. R98's medical record was reviewed, however, no information was identified she had been provided the required notices of Medicare non-coverage prior to her Medicare services ending. During interview on 10/26/15, at 2:14 p.m. social worker (SW)-A stated there was no documented evidence R98 was provided a Notice of Medicare Provider Non-Coverage (CMS-10123). R98 was admitted for a therapy stay at the facility, and

Minnesota Department of Health STATE FORM

auidelines."

should have been given the denial notice two days before her covered services ended.

During follow up interview on 10/26/15, at 2:55 p.m., SW-A stated the facility did not have a policy on ensuring the liability notices were given correctly, rather they, "Just follow Medicare

SUGGESTED METHOD OF CORRECTION:

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	MULTIPLE CONSTRUCTION JILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015	
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAF D, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21800	and/or revise facility related to liability ar Medicare non-cove could be re-educate procedures. Approprovided for individual deficiency, with supmaintained. An audeveloped and imputing with the facility's Quassurance committed compliance.	ge 116 or designee, could review y policies and procedures and appeal rights notices for rage. Responsible personnel ed on these policies and priate notices could be ual(s) identified in the aporting documentation diting system could be lemented, with results shared uality Assessment & ee, to ensure on-going	21800				
21805	Residents of HC Farsubd. 5. Courteour residents have the courtesy and resperent employees of or perhealth care facility. This MN Requirements: Based on observation review, the facility farsubday: Based on observation review, the facility farsubday: This MN requirements: This MN requirements: Based on observation review, the facility farsubday: Based on observation review, the facility farsubday. Based on observation review, the facility farsubday.	ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a ent is not met as evidenced on, interview and document ailed to provide timely eting aftercares and ensure nence products were provided (R126) who expressed ified care and services. Minimum Data Set (MDS)	21805	Corrected.		12/29/15	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			7. BOILDING.			
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	ΩΕ ΒΠΕΕΔΙ Ω	BOULEVAR MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 117	21805			
	cognition, required toileting, and was "a R126's care plan da were to provide income."	tified R126 had intact extensive assistance for always" continent of bowel. ated 10/12/15, identified staff ontinence products for R126 ovide assistance from one staff				
	During interview on stated he was dependence because he was unwheelchair by hims anxious and helplet for up to 30 minute answered, which or R126 reported two close calls" with both having to wait for exassistance, and add to complete post to provided bed pan. bottom that would be left on the bed pan himself down on not to keep the linens of could assist him with felt this was undign (FM)-D was present R126's statements were accurate. On stated he had a both and again placed in when finished utnil with clean up. R12 "I just feel so helple visible tears in his example."	a 10/20/15, at 3:22 p.m. R126 endent on staff for assistance hable to walk or get to his elf, which made him feel as. R126 stated he had waited as before to have his call light haly increased his anxiety. instances of having "very wel incontinence because of extended periods of time for ded he still required assistance illeting care after using the R126 had a sore on his become worse and painful if too long, so R126 raises a pan and removes it, the sets ewspaper he places on the bed from becoming soiled until staff the cleaning. R126 stated he ified. R126's family member at for the interview, and stated of lack of toileting aftercare 10/23/15, at 7:03 a.m. R126 wel movement that morning, ewspaper underneath of him staff were able to assist him 6 became tearful, and stated, ess." R126 continued to have eyes, stated he could not ew, and requested the				

Minnesota Department of Health

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	,	
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	On 10/26/15, at 10 not prefer to use not while waiting for sta "That is how I have system." He did have system." He did have system." He did have system." He did have was unable to use impairments, and the presented to him way wear, "A big diaper offerd a disposable collect fluids). Agaduring the interview and feelings of help over when they are When interviewed nursing assistant (IR 126 in the past wis soiled newspapers had never asked R newspapers before was having to use it assisted him. During interview on registered nurse (F continent of bowel, bedside had been to prefer the use of a RN-H was unaware underneath of hims with clean up, and were available and stated she expecte R126 was observed manner.	2:100 a.m. R126 stated he did ewspaper underneath of him aff assistance, but added, eleaned to work with the ave wetted wipes available, but se them due to his mobility he only option the staff ersus using newspaper was to ." R126 stated he was never chux (absorbent pads used to in, R126 became teary eyed or, and expressed frustration plessness, "I have no control egoing to come and help." On 10/26/15, at 10:27 a.m. NA)-A stated she had assisted ith toileting cares, and seen on his bed. NA-A stated she 126 about the soiled ethough, and was unaware he it as a barrier until staff 10/26/15, at 2:18 p.m. RN)-H stated R126 was always and a commode at his tried, but R126 tended to bedpan over a commode. R126 was placing newspaper self until being assisted by staff added several other products could be used. Further, RN-H d staff to report it to her if d using newspaper in that				
		(DON) stated she was susing newspaper as a barrier				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 119 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	to protect his bedding assistance with clear "innovative" solution pads were not routing they could have been as letter submitted properties to part and they could have been as letter submitted properties to clean myst white. I don't want to pan out I put the new seep from getting myst my light on for some pan and clean menu knows we are busy for himself. As indicexpressions and shindicate that he was dignity was being conself-action." A letter submitted properties [R126] would the newspapers under arrival. He had the land they himself on bedpan, was done." A letter submitted properties for bedpan, was done."	ng while waiting for staff an up, but added it was a n. The DON stated disposable nely used in the facility, but en ordered for R126. ost survey exit, dated by the DON and signed by the ed, "He [R126] states he uses is body up and place himself a bowel movement, 'I can't elf. The cover on the bed is o get it dirty so when I take the wspaper under my butt to narks on the blanket. Then I someone to come and get the and he can do some things eated with matching facial oulder shrugs [R126] did not is bothered or feel that his comprised with this innovative ost survey exit, dated by NA-T noted, "A couple of have his light on but he put der him prior to the [NAs] bedpan within reach and put notifying staff only when he ost survey exit, dated by NA-D noted, "[R126] chose ander himself even though I eed to do that and we would to soiled. He continued to put	21805			

6899

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
			7. 50.251110.				
		00714	B. WING		10/2	6/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21805	Continued From pa	age 120	21805				
	services was reque	ested, but was not provided.					
	SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to dignified care and services. Responsible personnel could be re-educated on these policies and procedures. Care practices for the individual(s) identified in the deficiency could be reviewed and/or revised for compliance with these policies, with supporting documentation maintained. Other residents could be evaluated for dignified care and services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.						
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen					
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			12/29/15	
	Subd. 10. Particip notification of family	pation in planning treatment; y members.					
	in the planning of the includes the opport alternatives with incopportunity to requestare conferences, a family member or oboth. In the event to present, a family member and the includes the includes a family member or oboth.	Il have the right to participate neir health care. This right tunity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be ember or other representative dent may be included in such					

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 121 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKI	DDRESS, CITY, SE BOULEVARD, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	(b) If a resident we unconscious or concommunicate, the fefforts as required the either a family memoriting by the reside an emergency that admitted to the facifamily member to perform the performance of the consequence of	ge 121 who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify iber or a person designated in ent as the person to contact in the resident has been lity. The facility shall allow the articipate in treatment e facility knows or has reason ent has an effective advance trary or knows the resident has that they do not want a family intreatment planning. After ember but prior to allowing a articipate in treatment which make reasonable with reasonable medical ne if the resident has ce directive relative to the redecisions. For purposes of asonable efforts" include: the personal effects of the resident has a the resident has a the resident normally goes for the resident normally goes for the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, at has executed an advance of the physician to whom the oes for care, if known, and the physician to whom the oes for care, if known,	21830			

STATEMEN	TA DEPARTMENT OF HE IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00714	B. WING	B. WING		6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	10/1	0,2010
		310 I AKF	BOULEVAF	•		
LAKE RI	DGE CARE CENTER (OF BUFFALO), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
21830	the notification of the emergency contact family member was patient's privacy rigil (c) In making rea family member or described the facility shall attemembers or a design examining the personal the medical reconstruction of the facility a family memorgency contact admission, the facility social service agency that the resist the facility has been member or designated emergency contact admission, the facility has been member or designated county social service agency or location of the facility in and notification of the facility subdivision is not lied damages on the grother family member or designated emergency or location of the family member or designated emergency or location of the family member of the famil	r damages on the grounds that e family member or or the participation of the improper or violated the hts. sonable efforts to notify a esignated emergency contact, and to identify family gnated emergency contact by onal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and in unable to notify a family ted emergency contact. The e agency and local law y shall assist the facility in local law enforcement agency or in implementing this able to the resident for bunds that the notification of or emergency contact or the	21830			
	or violated the patie	family member was improper ent's privacy rights. ent is not met as evidenced				
	Based on interview facility failed to hone 3 residents (R73) re Findings include:	and document review, the or bathing preferences for 1 of eviewed for choices. nimum Data Set (MDS) dated		Corrected.		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 123 of 137 28WI11

Minnesota Department of Health

Minnesota Department of Health				_	,	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	00714		B. WING		10/2	6/2015
					10/2	.0/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF			
		BUFFALO	D, MN 55313			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	NEGOLATORI OR E	30 IDENTIF TING IN ORIVIATION)	TAG	DEFICIENCY)	THAIL	BALL
21830	Continued From pa	ige 123	21830			
	10/1/15, indicated h	ne was cognitively intact,				
		o staff with bathing, and it was				
		be able to chose the method in				
	which he was bathe					
		ted 9/25/15, identified he had				
		eptember 2015, but did not				
		nces or assistance R73				
	required with bathin	ng. R73's undated Nursing				
	Assistant Care She	et indicated he received a tub				
	bath on Thursday b	y an outside agency.				
	During interview 10	/21/15, at 10:02 a.m. R73				
		be giving me two baths a				
		y is supposed to also be giving				
		ek. R73 then stated, "I have				
		aths from the facility since I				
	have been here."					
		reek Bridge Weekly Bath and				
		1/15 to 10/22/15, identified the				
	following:	/15 to 0/27/15 D72 was not				
	identified on the ba	/15 to 9/27/15, R73 was not				
		1/15 to 10/4/15, R73 continued				
	to not be identified					
		5/15 to 10/11/15, R73 was				
		ve four baths, but only had one				
	bath documented a					
		2/15 to 10/18/15, R73 was				
		receive four baths, but only				
		mented as being completed.				
		9/15 to 10/22/15, R73 was				
		ve three baths, but only had				
		nted as being completed.				
		ntified R7 received two baths				
		two baths from the outside				
		out of the 11 baths he should				
	have received.					
		/23/15, at 9:15 a.m. nursing				
		ated the staff do the best they				
		e do not have a bath aide and				
	we just can't get all	of them done so some of the				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 124 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
	PROVIDER OR SUPPLIER	OF BUFFALO 310 LAKE	DRESS, CITY, S BOULEVAR , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21830	baths have been m During interview 10 nurse (RN)-A stated his bath according to not documented on completed. A facility policy on of none was provided. SUGGESTED MET The director of nurs and/or revise facility related to resident of planning of their bath personnel could be and procedures. A could be made to h of the individual(s) i with supporting door residents could be of regard to their bath system could be de with results shared Assessment & Assi on-going compliance	issed. That's all I can say." /23/15, at 9:21 a.m. registered to R73 should have received to his choice adding if it was the listing, it was not thoices was requested, but thoices and procedures choice and participation in thing schedules. Responsible re-educated on these policies propriate accommodations onor the bathing preferences dentified in the deficiency, the thoice and implemented, with the facility's Quality urance committee, to ensure	21830			
21870	Residents of HC Fa Subd. 18. Respor residents shall have	ac.Bill of Rights acsive service. Patients and the right to a prompt and se to their questions and	21870			12/29/15
	This MN Requireme	ent is not met as evidenced				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015	
	PROVIDER OR SUPPLIER	OF RUFFALO 310 LAKE	DRESS, CITY, SE BOULEVARD, MN 55313				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21870	by: Based on interview facility failed to prove resident council growith inadequate state affected 5 of the 48 R35 and R21) who council meetings from Findings include: During the recertific council minutes we following: The resident councindicated under nurwed on thave enclong it takes for the Writer [activity direct difference between vs. [versus] being slacked any further cresidents, or develor R27, R19, and R45 staffing. A follow up Form dated 8/12/15 (DON) provided a residents are requestime. We are getting quickly as possible Some employees a while they are learn The resident councidentified, "Updates were addressed, he R35 again stated," need of more nursed on thave enough is the nature of the to be busy and to updates.	and document review, the vide timely follow-up to the sups grievance as concerned ffing in the facility. This residents (R27, R19, R45, regularly attended resident om 7/28/15 to 9/29/15. Cation survey, the resident re reviewed and identified the sil minutes dated 7/28/15, sing R27, R19, R45, "All feel ough nursing help due to how ir call lights to be answered. Cotor (AD)] explained the cutting hours due to census hort staffed." The minutes discussion, input from the comment of a plan to address 's voiced concerns with the Resident Council Action of the first of the same of the graph of the	21870	Corrected.			

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 126 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. Bolebina.			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE R	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21870	minutes lacked any the residents, or de address R27, R21, concerns with staffic Council Action Forma response by the It to run ads & hire newith retention too! times with a picture it]!" The resident council about staffing. Wri [R21] had concern for too long. Writer requirement for a Noregistered] to be about staffing at the facility management team During interview on stated she did not for the council meeting. "They are so short sometimes I have to help me you see to get on the bed provement] and who I have an accident pleasant for me." During interview on who stated she is in council meetings. It complain about the problem everywher their concerns. I all	r further discussion, input from evelopment of a plan to R19, R35, and R45's voiced ing. A follow up Resident in dated 8/25/15, completed as DON indicated, "We continue ew employees continuously Thank You [underlined several e of a smiley face drawn next to ill minutes dated 9/29/15, members are concerned ter [AD] explained staffing. about waiting to go to his meal explained about the IAR's [nursing assistant, ple to sit with residents who and that this way likely the eait." There was no evidence erns regarding inadequate ty were addressed by the	21870			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21870	Continued From pa	ge 127	21870			
21870	Although R27, R19 complaints of staffir continued at the 8/1 council meetings w plan being identified staffing. The facility Grievandated 1/12/12, indic Ridge Care Center that enhances reside and peace of mind the opportunity to your facility." The poresident, their represended to bring of the appropriate of the appropriate of the staffing of the appropriate of the appropriate of the staffing of the appropriate of the appropriat	R45, R35 and R21 had ag on 7/28/15, their concerns 3/15 and 9/29/15 resident ith no objective, measurable doto resolve there concerns of the ces and Complaints policy sated "it is the policy of Lake to provide and environment lent dignity, security, comfort by allowing residents and staff poice their concerns to improve olicy further indicated "If a sentative, family member or occur with any aspect of care, or the facility; they are gothat concern to the attention department manager." THOD OF CORRECTION: Sing or designee, could review of policies and procedures council grievances. The could be re-educated on procedures. Appropriate ution of resident council en made, with supporting intained. An auditing system and implemented, with	210/0			
	on-going compliance					
	TIME PERIOD FOR days.	R CORRECTION: Thirty (30)				
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			12/29/15

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
007	714	B. WING		10/2	6/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF BUFFA	ΔΙ ()	BOULEVAR , MN 55313	D		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE F TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Subd. 20. Grievances. Pashall be encouraged and assister stay in a facility or their to understand and exercise in patients, residents, and citizer residents may voice grievance changes in policies and servand others of their choice, frointerference, coercion, discrincluding threat of discharge grievance procedure of the fewell as addresses and teleph Office of Health Facility Connursing home ombudsman patericans Act, section 307(posted in a conspicuous place) Every acute care inpatient residential program as define 253C.01, every nonacute cafacility employing more than provides outpatient mental have a written internal grievat a minimum, sets forth the followed; specifies time limits limits for facility response; pror resident to have the assist advocate; requires a written grievances; and provides for an impartial decision maker otherwise resolved. Compliates and programs as define 253C.01 which are hospital-treatment programs, and outcenters with section 144.691 health maintenance organizate 62D.11 is deemed to be comrequirement for a written internal programent internal contents with section 144.691 health maintenance organizate for a written internal contents with section 144.691 health maintenance organizate for a written internal contents with section 144.691 health maintenance organizate for a written internal for a written i	sisted, throughout course of treatment, their rights as ens. Patients and ces and recommend ices to facility staff ee from restraint, mination, or reprisal,. Notice of the acility or program, as none numbers for the nplaints and the area cursuant to the Older a)(12) shall be ce. If facility, every two people that ealth services shall ance procedure that, process to be so, including time rovides for the patient stance of an response to written a timely decision by if the grievance is not ance by hospitals, ined in section based primary tpatient surgery and compliance by ations with section upliance with the	21880			

6899

PRINTED: 12/10/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00714 10/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21880 Continued From page 129 21880 procedure. This MN Requirement is not met as evidenced Based on interview and document review, the Corrected. facility failed to attempt to resolve an individual grievance for 1 of 1 residents (R45) who had expressed concerns over lift placement and bruising. Findings include: R45's annual Minimum Data Set (MDS) dated 8/11/15, indicated R45 was cognitively intact and required assistance of two staff for transfers. A Resident Council Action Form dated 8/12/15. indicated that R45 "had complaints that when she brings a complaint to a nurse she feels they do not take her seriously... Had concerns about lift with sling placement and bruising [R45] felt she wasn't taken seriously." The action form indicated it was given to the DON. The form indicated the director of nursing (DON) response: "[R45] was not feeling well and gets paranoid/depressed with illness. this writer did visit with her and that she down played the concern."

lift. Minnesota Department of Health

During interview on 10/22/15, at 2:10 p.m. the DON stated she was aware of R45's concern but did not feel it was a big deal. The DON stated it was about the lift but never investigated if there was bruising or how the staff were transferring the resident. The DON had not implemented any actions in effort to resolve R45's concern with the

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (` '	(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 130	21880			
	During interview on R45 stated the staf when she made a comonths ago when sher ceiling lift, the scorrectly and it slid causing a skin tear "irritated" because resident council", b done about it." A facility Grievance 1/12/12, indicated, Care Center to proven the comportunity to voice facility." Further, the resident, their representation of the appropriate of the appropriate of the appropriate of the seponsible person these policies and person the person these policies and person the person these policies and person the person the person that the person that th	10/23/15, at 12:23 p.m. with f did not always listen to her concern. R45 stated a few she was being transferred from trap was not connected down on her right arm, and bruising. R45 was she "made a grievance in ut didn't "think anything was she "made a grievance in ut didn't "think anything was she "made a grievance in ut didn't "think anything was she "made a grievance in ut didn't "think anything was she "made a grievance in ut didn't "think anything was she "made a grievance that dignity, security, comfort and llowing residents and staff the entheir concerns to improve our explicitly indicated, "If a seentative, family member or incern with any aspect of care, or the facility; they are gothat concern to the attention department manager." THOD OF CORRECTION: Sing or designee, could review by policies and procedures and procedures resident grievances. The could be re-educated on corocedures. Grievances could be individual(s) identified in the oporting documentation residents could be evaluated tonse to voiced grievances.				
	An auditing system implemented, with	could be developed and results shared with the facility's t & Assurance committee, to				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. 501251110.			
		00714	B. WING		10/2	26/2015
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF RUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 131	21880			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults		21980			12/29/15
	Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:					
	another facility and believe the vulnera previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in thi known or suspecte knows or has reaso been made to the c (d) Nothing in thi reporter from also ragency. (e) A mandated reason to believe the	as admitted to the facility from the reporter has reason to ble adult was maltreated in the mows or has reason to believe a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the ection may voluntarily report as section requires a report of dimaltreatment, if the reporter on to know that a report has common entry point. It is section shall preclude a reporting to a law enforcement reporter who knows or has that an error under section in 17, paragraph (c), clause				

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00714	B. WING		10/2	6/2015
NAME OF				CTATE ZID CODE	10/2	.0/2015
	PROVIDER OR SUPPLIER	310 I AKE	BOULEVAF	STATE, ZIP CODE RD		
LAKE RI	DGE CARE CENTER	OF RUFFALO	, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	(5), occurred must subdivision. If the use time believes that a agency will determine the reported error with the criteria under set 17, paragraph (c), of acility may provided directly to the lead a how the event mee 626.5572, subdivisi (5). The lead ager information when must the report under sufficiently failed to ensure neglect and injuries immediately reported agency and thorough residents (R45, R16 allegations were refindings include: R45's annual Minima 8/11/15, indicated serequired assist of two A Resident Council indicated that R45 brings a complaint not take her serious lift with sling placen she wasn't taken serious was given to the D0 serious in the poor the	make a report under this reporter or a facility, at any an investigation by a lead ne or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or to the common entry point or agency information explaining to the criteria under section 17, paragraph (c), clause ney shall consider this naking an initial disposition of bdivision 9c. The total paragraph (c) and the tribute of the entry of the tribute of the tribute of the tribute of the entry of the tribute of the entry of the tribute of the entry	21980	Corrected.		

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 133 of 137

Minnesota Department of Health

I I	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:	
00714 B. WING 10/26/20 ⁻		/26/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	OVIDER OR SUPPLIER	
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313	GE CARE CENTER	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	(EACH DEFICIENCY	(X5) COMPLETE DATE
paranoid/depressed with illness did visit with her and that she down played the concern." During interview 10/22/15, at 2:10 p.m. the director of nursing (DON) stated she was aware of R45's concern but didn't feel it was of concern. The DON stated R45's concern with the lift was never investigated including if there was bruising or how the staff were transferring the resident, nor was it reported to the State agency. Further, the DON stated she was was not aware of any bruising on R45. During interview 10/23/15, at 12:23 p.m. R45 stated the staff don't always listen to her when she voices a concern that they (staff) can be rough. R45 stated she was being assisted to transfer a few months prior, and the strap used by the ceiling lift was not attached correctly which caused it to slide down and cause a skin tear and bruising on her arm. R45 stated she was "irritated" because during the transfer, she yelled out "owe, owe", but the staff did not stop the transfer. The staff proceeded to transfer her, despite her cries of pain, stating "it's OK." Although R45 reported during a transfer of staff being rough causing a skin tear and bruising there was no indication the administrator and the state agency were immediately notifed, nor had an investigation been completed of the allegation. R104's admission MDS dated 6/11/15, indicated he was cognitively intact and feels depressed. An Incident report dated 6/29/15, indicated that on 6/26/15 in R104's room, "Writer got to the door and overheard a mans loud voice that was not	paranoid/depressed are and that she do During interview 10 director of nursing (of R45's concern by The DON stated R4 never investigated for how the staff well are the DON stated she boruising on R45. During interview 10 stated the staff don she voices a concern ough. R45 stated aransfer a few month he ceiling lift was recaused it to slide do bruising on her arm irritated" because out "owe, owe", but ransfer. The staff despite her cries of Although R45 report of the properties of the staff and investigation because of the staff and investigation because of the staff despite her cries of the staff and investigation because of the staff despite her cries of the staff despite	

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 134 of 137

Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00714	B. WING		10/2	6/2015		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21980	Continued From pa	ge 134	21980					
	to hear what was all word "Fuck", and "y tone of voice. Write with nurse and saw (FM)-A was yelling asked if he wanted yes. FM-A was ask writer before he corthe time was holdin and was pointed to asked if his FM-A w stated yes. Writer a permission to do th Resident also state been physically abuthreatened to kill hir residents home. Reactually pushed him home to try to kill hir to show for it. Resiknow if he wanted is since he has been helping him. Reside FM-A now had keys refusing to give thoresident, "you will hyou think you are galso stated FM-A had give that back. The to the state agency. During interview 10 DON who stated the immediately reported Although the incide facility did not reported.	I being said but did her the your and Asshole" in an angry er immediately went into room resident's family member at resident. Resident was FM-A to leave. Resident said and to leave several times by implied with leaving. FM-A at g up his phone that had a light wards resident. Resident was vas video taping him. Resident asked resident stated "no". In the past, is and resident stated "no". In the past while at esident stated that FM-A had in into a bonfire at residents im, and he still had the scars dent express that he didn't fm-A back here at the facility the only one that has been ent also let writer know that is to his home, truck and was see back. FM-A told the ave to break into your house if ong back there". Resident as his laptop and refusing to envestigation was submitted on 7/01/15. 1/26/15, at 6:13 p.m. with the end and she did not know why it late.						

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 135 of 137

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00714	B. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR , MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 135	21980			
	she was moderately extensive assist of An Investigative Re that on 4/3/15 R131 area to the lateral lead (centimeter) by reassessed for her transferred in this ty determined to require administrator a informed of the incident and the investigation agency on 4/13/15,	DS dated 2/25/15, indicated y cognitively intact and needed two with transfers. sport dated 4/5/15, indicated I had a, "exp. large discolored eft breast" which measured 10 8 cm in size. R131 was ability to continue to be ype of device, and R131 was ire a hoyer lift for transfers. and the state agency was dent on 4/5/15 two days later on was submitted to the state 10 days after the incident fied the injury was from a				
	stated the investiga know why it was se computer glich". Fu	/22/15, at 2:17 p.m. DON tion was sent late and didn't nt late "maybe it was a wrther, the DON stated and the location, the incident ted.				
	facility failed to info the state agency tw	was noted on 4/3/15, the rm the administrator and and to days later and the ot reported until 10 days later.				
	Policy and Procedu indicated "Each em suspected/alleged v abuse/neglect imme following: Nursing s Director of Nursing,	rable Adult Abuse Prohibition re revised November 2011, ployee is responsible to report violations of resident ediately to one of the supervisor, Nurse on Duty, or Social Worker. The enotified immediately by on of				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 136 of 137

PRINTED: 12/10/2015 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00714 10/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 LAKE BOULEVARD LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21980 Continued From page 136 21980 the above. Staff may go immediately to the Administrator if desired. Report all alleged violations and substantiated incidents immediately to the state agency and all other agencies as required (oral report to CEP (common entry point) and electronically to MDH (Minnesota Department of Health)." The policy further indicated "All reports of resident abuse. neglect and injuries of unknown source shall be promptly and thoroughly investigated." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to abuse prohibition. Responsible personnel could be re-educated on these policies and procedures. Reports of abuse/ neglect/ injuries of unknown origin could be reviewed for compliance with these policies, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.

6899

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUR COMPLETE				
		00714		B. WING		10/2	26/ 2015
	PROVIDER OR SUPPLIER	OF BUFFALO	310 LAKE	DRESS, CITY, S BOULEVAF D, MN 55313		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	MN Rule 4658.0510 Staffing requirement Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants to residents at all nursing all buildings if more involved. This inclused and vacation replaced. This MN Requirement by: Based on observation review, the facility for staffing to ensure reassistance with carreviewed for dignification reviewed for dignification for 5 of 6 residents (R73) reviewed for gresidents (R5) reviewed for (ADLs). In addition R55, R85, R118, R82 of 4 family members (INA-T, NA-K, LPN-FCOTA-J, SM-A and concerns and computating. This lack of the facility. Findings include: ASSESSED RESID	requirements. An an duty at all times a nursing personnel icensed practical no meet the needs of ses' stations, on all fore than one building des relief duty, we seements. The stations of all fore than one building relief duty, we seements. The stations of all forest is not met as even on, interview, and contained to provide addesticed to provide addesticed for 1 of 2 residents received the set of 1 of 2 residents and services is (R27, R19, R45, R19, R45, R19, R45, R19, R45, R19, R64, R45, R19, R45, R45, R45, R45, R45, R45, R45, R45	ursing sufficient I, including nurses, and of the floors, and g is ekends, videnced document equate ne required nts (R126) es, for 1 of 3 hoices, for R35 and I of 3 iene, and ving s (R126, and R27), and 13 of NA-C, r-K, expressed sufficient d potential resided in	2 800	Corrected.		12/29/15

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/27/15 **Electronically Signed**

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00744	B. WING		(10/0	
		00714	D. WING		10/2	26/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF D, MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	Continued From pa	age 1	2 800			
	MET:					
	timely assistance w failed to ensure approducts were prov	ne facility failed to ensure with toileting aftercare's and propriate incontinence wided, for 1 of 2 residents ased concerns of undignified				
	*Refer to F242: The bathing preference reviewed for bathing	ne facility failed to honor s for 1 of 3 residents (R73) ng choices.				
	*Refer to F244: The facility failed to ensure prompt responses to grievances related to staffing concerns. This had the potential to affect 5 of the 48 residents (R27, R19, R45, R35 and R21) who regularly attended resident council meetings from 7/28/15 to 9/29/15.					
	cares as directed b	ne facility failed to provide oral by the care plan for 1 of 3 ewed for dental hygiene.				
	care was complete R64), bathing complete (R45, R19), and as provided for 1 of 5	e facility failed to ensure nail d for 2 of 5 residents (R5, pleted for 2 of 5 residents esistance with toileting was residents (R126) reviewed for ring (ADLs) and who were for their care.				
	RESIDENT CONC	ERNS ABOUT STAFFING:				
	dated 9/29/15, iden	Minimum Data Set (MDS) ntified R126 had intact ntired extensive assistance to				
	During interview or	n 10/22/15, at 3:22 p.m. R126				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 2 of 13

Minnesota Department of Health

	it of periornoire		(VO) MULTIPL	E CONCERNICATION	(VO) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	LETED
	-		A. BUILDING:			
			D WING		C	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE DI	DOE 04DE 05NTED	310 LAKE	BOULEVAF	RD		
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO			, MN 55313			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
2 800	Continued From pa	ige 2	2 800			
		ait up to thirty minutes to have				
		red to receive assistance with				
		he needed staff assistance to				
		nd get into his wheelchair, and				
		long it would take staff to				
		t and that made him feel,				
		lpless." During a follow-up				
	interview on 10/26/15, at 10:00 a.m. R126 stated					
	his preference was to use a commode for					
	toileting and not a bedpan. However, due to long response times, he often utilized a bedpan. He					
		p to get on and off the				
		nable to get onto the commode				
		ait for staff to help. R126				
		nave much rather used a				
		ng and not a bed pan,				
		t get as "messy," But staff				
		o his call light for assistance				
		the commode, so he has to				
		d not the commode, which he				
	prefers to use.					
	Dee	0.1.104-4-11				
		S dated 9/15/15, identified				
		cognitive impairment, and				
	required limited ass	sistance from staff for ADLs.				
	During interview on	10/20/15, at 9:13 a.m. R55				
		d to wait for extend periods of				
		he bathroom, and was				
		ent because of waiting for so				
		he facility needed more staff to				
		their cares, "They just don't				
	have the people to					
	the poople to					
		S dated 9/1/15, identified R85				
		ı, and required extensive				
	assistance from sta	aff to complete ADLs.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00714	B. WING		10/0	
		00714	2		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	()F BIIFFAI ()	BOULEVAF), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 3	2 800			
	stated the facility ha the past two or thre takes, "Quite awhile	10/20/15, at 10:03 a.m. R85 ad been, "Short of staff," for e months. R85 stated staff e" to answer his call light to with cares, and it had, "Been a				
	R118 had intact cog	MDS dated 8/24/15, identified gnition, and required limited lift to complete ADLs.				
	stated staffing seen in the evenings. R1 that needed to be c resident had to wait	10/21/15, at 11:34 a.m. R118 ns worst on the weekend and 118 had a dressing change ompleted, however, the tover 6 hours for staff to a caused the dressing to and drip fluids.				
	had intact cognition	dated 9/15/15, identified R5, and required extensive iff to complete ADLs.				
	stated the facility did staff would often co staffed to him, and was only one nurse R5 stated his call lig minutes," to get ans	10/20/15, at 9:11 a.m. R5 d not have enough staff, and implain about being short at times R5 had stated there working for an entire shift. If the will take, "Fifteen to twenty swered, and was once left on An hour and a half," before the assistance.				
	R73 had intact cogr	DS dated 10/1/15, identified nition, and required extensive aff to complete ADLs.				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00714	B. WING		10/2	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF , MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 4	2 800			
	stated he had waite past for staff assist call light to be answ over worked and ur	10/21/15, at 10:55 a.m. R73 ed for nearly two hours in the ance to go to bed and for his vered. R73 stated the staff are nder staffed for the residents necessary cares in the facility.				
	R35 had moderate	S dated 10/6/15, identified cognitive impairment, and assistance from staff to				
	stated the facility st the time, and there have to wait to use	10/20/15, at 10:29 a.m. R35 aff worked short nearly all of had been times R35 would the bathroom but was not receiving timely assistance the restroom.				
	R123 had intact co	MDS dated 10/15/15, identified gnition, and required extensive aff to complete ADLs.				
	stated she had wait to the restroom, ca	10/20/15, at 12:20 p.m. R123 ted for over an hour to get help using her to, "Just use my stated made her, "Feel				
	R27 had intact cog	S dated 9/22/15, identified nition, and required extensive aff to complete ADLs.				
	stated she had wait her call light answe	10/20/15, at 10:24 a.m. R27 ted for over an hour to have red to receive assistance, and to have more staff to provide				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 5 of 13

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00714	B. WING			C 26/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	E BOULEVAR O, MN 55313	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 5	2 800			
	the cares the reside	ents needed.				
	FAMILY COMPLAIN	NT'S ABOUT STAFFING:				
	member (FM)-G stafamily member in the requesting staff assistated, and waited, staff to respond. The occurrences of waited answered, and FM-response times] couthey had been told they were "Adequated disagreed and the first staff to help resider. During interview on stated he had notice not being completed at the facility. The object of the staff to help resider.	10/26/15, at 10:01 a.m. FM-H ed oral cares were frequently d because of the lack of staff call light had taken over one d in the past, and was				
	STAFF CONCERN	S ABOUT STAFFING:				
	nursing assistant (N facility needed more with cares. NA-G s complain about the and lack of assistar NA-G stated the sc (nail care, shaving) because of the lack don't have enough?	10/22/15, at 10:38 a.m. NA)-G stated she felt the e staff to assist the residents attated the residents often long call light response time not they receive with cares, heduled baths and grooming is not always completed of staffing adding, "[staff] time to take care of the tated several staff had been				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 6 of 13

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00714	B. WING			6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAF			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	, MN 55313	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 6	2 800			
	by themselves becastaff on to help us of administration tells but rarely help staff ensure they are being buring interview on housekeeping aide had been short staff had made residents extended periods, a rooms and hear resme." HA-A stated	to care for two assist residents ause, "There's not enough out." NA-G stated the facility staff they, "Are looking into it," provide the resident cares to ang completed. 10/22/15, at 10:53 a.m. (HA)-A stated the nursing staff fed lately. The lack of staff is have to wait for help for and HA-A will often walk by sidents asking, "Help me, help administration is aware of the nable to assist residents with				
	cares, but they tell of add more staff, "Bu During interview on	employees they are trying to				
	and there was frequeach hallway to pro The residents frequeights were not answered lack of staffing, "The care they should gamembers were injurable for so long, and	uently only one or two NA's on wide cares to the residents. Hently had to wait, and call wered timely because of the ey [residents] don't get the et." NA-I stated several staff red because they waited for d nobody came, so they sidents in bed by themselves.				
	stated the staffing was supposed to hat for the residents du frequently is left wit at times on the ween nurses and two NA residents, and on the staffing was staffed.	10/22/15, at 1:36 p.m. NA-C was "awful," adding the facility ave six or seven NA's to care uring the morning shift, but h only four NA's. NA-C stated exend there would be just two 's to care for all of the nat weekend, no residents duled bathing, and beds were of the lack of staff.				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 7 of 13

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.			
		00714	B. WING		10/2	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKE RI	DGE CARE CENTER	OF BUFFALO	BOULEVAR), MN 55313			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	age 7	2 800			
	stated the facility w care was suffering instances of only or for residents in the the residents have and attention. NA- grooming of reside times," because of the administration I ago and talked abo however, nothing h	n 10/22/15, at 1:53 p.m. NA-T ras short staffed and resident as a result. There had been ne NA on each hallway to care past, and when that occurs to, "Just wait," to receive care T stated the bathing and nts had suffered, "Lots of the poor staffing. NA-T stated held a meeting a few months out solutions to short staffing, and been done to improve not ff, and nothing further had				
	stated staffing at the horrible," and residestated there was from covering the Oasis and residents had to get their call light [staff] don't have tire administration had cares, but "they expressed work done and only you guys [state sure During interview on licensed practical in "Not adequate," to needs, and she was facility because she and felt it was being the lack of staffing as a result.	n 10/22/15, at 2:53 p.m. nurse (LPN)-F stated staffing is care for the residents and their is quitting her position at the evalued her nursing license, giput in jeopardy because of and poor care being delivered				
		n 10/23/15, at 7:07 a.m. LPN-B facility did not have enough				

Minnesota Department of Health

STATE FORM 28WI11 If continuation sheet 8 of 13

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00714	B. WING			C 26/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
LAKE RI	DGE CARE CENTER	OF BUFFALO	(E BOULEVAR .O, MN 55313	D			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 800	staff to provide the and residents had tand families voice for regarding the suffer poor staffing. LPN-dressing changes wourse did not have trying to help provide other residents. During interview on registered nurse (Rambig issue" at the short of help and the overall. RN-A state because of the pool had never asked the tobalance the work staff's input on how situation. During interview on occupational therapist assistance could use more held they hear from reside and waiting, "Way to answered. OT-Kanaware of any action address the short sufficiency in the past few days, surveyors] are here home after their ships.	necessary care to residents, o wait to get up for the day, rustration to the staff ring care as a result of the B stated she recalled some veren't completed because the time because they were busy le the necessary care for the 10/23/15, at 11:52 a.m. N)-A stated staffing had been facility. The floor staff are e residents care was suffering d several staff had resigned r staffing, and administration e staff about changing hours a better, or asked for floor to handle the short staffing 10/26/15, at 2:32 p.m. pist (OT)-K and occupational e (OTA)-J stated the floor staff p, and the biggest complaint dents was the lack of staffing oo long for [call] lights," to be and OTA-J stated they were not so being taken by the facility to	f t				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 9 of 13

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			`
	00714	B. WING		10/2	, 6/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
LAKE RIDGE CARE CENTER O	dD.				
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
SM-A stated several recent shift, but only and SM-A was told be (DON) to sign the case were completed. SM "Really upset," and se with cares on the floor only being done, "be surveyors] are here." During an anonymous "People are quitting raised concerns about or three staff on the residents. SM-B state administration regard having enough staff baths, and grooming however, nothing has the staff working on the 10/19/15, to 10/23/13 document identified (Oasis, Lake View La Northwoods), and pra staff members name were they were scheduled just one nurse and output of the staff were scheduled just one nurse and output of the staff were scheduled just one nurse and output one staff names identified one nurse and output o	cares are just not good." I baths were scheduled for a two of them were completed by the director of nursing are sheets identifying they M-A stated that made her, stated administration helping or was not typical, and was ecause you guys [state " us interview, SM-B stated, because of the staffing," and but some shifts with only two floor to work and care for the sted they spoke to ding the concern of not to complete timely toileting, go because of the lack of staff, ad been done to fix this. ake Ridge Care Center) isplayed the names of the floor for each shift, dated 5, were reviewed. The each unit of the facility ane, Mill Creek Bridge, and rovided blank spaces in which me was written to identify eduled to work. 0/19/15, the Oasis unit had tified as being assigned to ill Creek Bridge and ad open spaces identifying no do to work; and were left with one NA for each unit. The six of the thirteen spaces	2 800			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00714	B. WING			C 26/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	•		
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD DUE TO 10 T							
BUFFALO, MN 55313							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 10	2 800				
	> On the AM shift, 1 had no staff names to work on the unit. Northwoods had op names written in. E one nurse, and one providing care for the identified six of the identify staff, to be the control of the control of the identify staff, to be the control of the identification o	10/20/15, the Oasis unit again identified as being assigned Mill Creek Bridge and ben spaces with no staff Both units continued with just NA working on the floor ne residents. The document thirteen spaces used to blank. 10/21/15, the Mill Creek Bridged, only having a nurse accare to the residents. The document the residents. The document the thirteen spaces used to the thirteen spaces used to the thirteen spaces used to					
	had no nurse identi Creek Bridge and N had one nurse and cares. The docume	10/22/15, the Lake View Lane fied, and only one NA. Mill Northwoods again each only one NA identified as providing the thirtee on tify staff, to be blank.	g				
	no staff name ident work on the unit, ar have a nurse identi	10/23/15, the Oasis unit had ified as being assigned to not the Lake View Lane did no fied. The document identified spaces used to identify staff, the document identified iden	1				
	(DON) stated, "Righ staffing. It is the dri stated, "We work w resources] all the til staff." The DON ac everything else that	6 p.m. the director of nursing nt now we are just stuck on the liver of all the other evils." She with corporate HR [human me to get and retain good blodd, "I think that almost to we've identified [as potential are tied into it [staffing	e e				

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 11 of 13

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			,
		00714	B. WING			6/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKE RIDGE CARE CENTER OF BUFFALO 310 LAKE BOULEVARD BUFFALO, MN 55313						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	not be an issue if w floor." The DON st was well aware of t and the quality condinsufficient staffing staffing shortage be summer when stud there were also eig maternity leave as facility was still accestated they had del later in the week who discharged. When identified or address were not receiving stated, "This is one staffing we were second week of Se to have a bath aide September I think good wash ups." During interview on administrator stated determined based of they, "Have a lot oneeds." The facility down in census, an number of hours diresidents) to determined based of they, "Have a lot oneeds." The facility down in census, an number of hours diresidents) to determine the staffing, and the for staff adding it had be time."	are so many things that would be had enough people on the stated the facility management the facility's staffing shortage cerns resulting from an DON stated the facility's egan around the end of lents returned to college, and the facility staff who had left on well. The DON confirmed the epting new admissions, but ayed some admissions until then another resident was asked whether the facility had used concerns of residents who boths or oral cares, DON of the things that is tied to doing great until the first or eptember We are supposed to [but] have not had one since to everybody is getting really and of residents that have more of the size of the building, and of residents that have more of duses a formula (total vided by the number of hours per down one bed equals, "X. The administrator stated he attified there is a problem" with cus was to hire and recruit new been the focus, "For a long estaffing was requested, but	2 800			

Minnesota Department of Health

STATE FORM 6899 28WI11 If continuation sheet 12 of 13

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
00714	B. WING		C 10/26/2015				
-	IDRESS CITY S	TATE ZIP CODE	10/20/2	2013			
310 I AKE BOIJI EVARD							
LAKE RIDGE CARE CENTER OF BUFFALO BUFFALO, MN 55313							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE			
2 800 Continued From page 12	2 800						
SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to sufficient staffing. Responsible personnel could be re-educated on these policies and procedures. Staffing patterns could be evaluated for insufficiency, with input from residents, employees and families. Interventions could be identified and implemented to remedy the insufficiencies identified, with supporting documentation maintained. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.							

6899